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Health Care Access and Use Among Low-Income Children on Subsidized Insurance Programs in California

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INTRODUCTION

This paper examines how low-income children on two types of local, county-based insurance programs in California, CaliforniaKids and Healthy Kids, use health care services and access the health care system. All children insured by these programs are currently ineligible for the two major (full benefit) statewide programs for low-income children, Medi-Cal and Healthy Families, most often because they have undocumented immigration status. As a result, prior to enrolling, most children covered by these programs had little or no access to subsidized health insurance coverage.

Numerous studies have documented the benefits of providing subsidized health insurance coverage to low-income children. (See, for example, Newacheck et al. 1998; Davidoff et al. 2000; Dubay and Kenney 2001; Wooldridge, Kenney and Trenholm 2005). Indeed, three separate, ongoing evaluations of Healthy Kids programs -- in Santa Clara County, San Mateo County, and Los Angeles County – all have found that the programs significantly improved children's access to and use of medical and dental care and sharply reduced their unmet health care needs (Trenholm et al. 2007; Howell, Dubay and Palmer 2007; Trenholm et al. 2005). In addition, another recent study finds that Healthy Kids programs have reduced the rate of avoidable hospitalization among low-income children (Cousineau, Stevens, and Pickering, forthcoming).

Drawing on available sources, this paper provides a side-by-side summary of the features of the CalifoniaKids and Healthy Kids programs and the use of basic health care services among the children who are enrolled.[1] In addition, the paper compares the service use of children covered by these local programs to the service use among low-income children covered by the statewide Medi-Cal and Healthy Families programs. Given that most children on CaliforniaKids and Healthy Kids are undocumented and may have had particularly poor access to affordable insurance coverage in the past, their patterns of health care use once covered by these programs could differ significantly from other low-income, insured children in California. Comparing the health care use of these children to the

[1] Among these services are whether children have had a recent medical visit (preventive or any), dental visit, emergency department (ED) visit, or inpatient hospital stay.

"benchmark" of children enrolled in the Medi-Cal and Healthy Families programs offers a means to explore this potential difference.

As discussed below, the most notable distinction between the two local program types is that CaliforniaKids excludes inpatient care from its benefit package (with the assumption that coverage will be provided through a limited-benefit program within Medi-Cal, commonly known as emergency Medi-Cal). In addition, CaliforniaKids has higher cost-sharing than Healthy Kids and tends to have a smaller provider network. Disentangling how these and other differences might contribute to differences in the costs of the programs, or in childrens' access to and use services, is beyond the scope of this paper. However, the paper does offer an initial look at these issues, drawing on interviews with selected health plan and program staff at six different CaliforniaKids and Healthy Kids programs.

MAJOR SUBSIDIZED COVERAGE OPTIONS FOR CHILDREN IN CALIFORNIA[2]

CaliforniaKids began in 1992 and now operates in 23 counties, providing coverage to roughly 8,000 children between the ages of 2 and 18 who live in families with incomes below 250 percent of the federal poverty level (FPL) (Table 1).[3] CaliforniaKids provides these children access to a full range outpatient services, including medical, dental, vision, and mental health care services. As discussed below, the monthly premiums and some other features of CaliforniaKids can differ depending on the county, leading to some variation in the CaliforniaKids programs across the state. All CaliforniaKids programs, however, provide medical care through a partnership with Blue Cross of California. This partnership allows CaliforniaKids to continue serving children even if they relocate from the county where they had originally enrolled.

Healthy Kids began in 2001 as a single program for children residing in Santa Clara County, but it has since spread to provide health insurance coverage to roughly 84,000 children across 25 counties (Stevens et al. 2007). Eligibility for Healthy Kids extends into higher income ranges than eligibility for CaliforniaKids—typically up to 300 percent of the FPL. As a result, some children enrolled in Healthy Kids are U.S. citizens but fail to qualify for Medi-Cal or Healthy Families because their family income is above the eligibility limit (250 percent of the FPL). In contrast to CaliforniaKids, Healthy Kids is a full-scope program with benefits in most counties similar to the statewide Healthy Families program.

[2] One coverage program in California that is outside the scope of this study is the Kaiser Permanente Child Health Plan. Similar to Healthy Kids and CaliforniaKids, the Child Health Plan provides subsidized health insurance coverage to low-income children in the state who are ineligible for Healthy Families and full-benefit Medi-Cal. The Child Health Plan covers a comprehensive set of services, including outpatient medical and dental care, emergency services, and inpatient hospital care. Currently, the Child Health Plan insures about 55,000 low-income children across the state. (For more information, see https://www.kaiserpermanente.org/).

[3] The large majority of children enrolled in CaliforniaKids reside in four counties, Orange, Marin, Monterey, and San Diego. Several of the 23 counties have only a handful of enrollees. Many of these children relocated from one of the four "main" counties and the program retained their coverage. Basic information on the program is available at [www.californiakids.org].

Table 1. Summary of Subsidized Health Insurance Programs for Low-Income Children in California

	Local Programs		Statewide Programs			
	Healthy Kids	CaliforniaKids	Medi-Cal	Healthy Families	Emergency Medi-Cal	CCS
Outpatient Coverage	Full[a]	Full; except certain ED services[a,b]	Full[a]	Full[a]	Emergency services only	Treatment for eligible medical conditions[c]
Inpatient Coverage	Full	None[b]	Full	Full	Full	Treatment for eligible medical conditions
Family income limit	<300 percent of FPL (<400 in San Mateo Healthy Kids)	<250 percent of FPL	<100–200 percent of FPL depending on child's age	<250 percent of FPL	<100–200 percent of FPL depending on child's age	$40,000/year[c]
U.S. citizenship required	No	No	Yes (or legal residency)	Yes (or certain documented immigrants)	No	No

Sources: Health plan literature accessed by the internet (see report references); interviews with the CaliforniaKids executive director and staff in Marin and Orange counties; and Healthy Kids Health Plan staff in Los Angeles, San Francisco, Santa Clara, and Solano counties.

[a]Full benefits package includes comprehensive medical, dental, vision, prescription drug, mental health, and outpatient ED care. Programs have copayments for some services.

[b]CaliforniaKids can be used in conjunction with emergency Medi-Cal. The combined programs create a full scope benefit package that covers both outpatient and inpatient health care.

[c]CCS generally covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. Families with higher incomes may qualify if they establish that the child's medical expenses for the medical condition are expected to exceed 20 percent of the household's income.

CCS = California Children's Services; ED = emergency department; FPL = federal poverty level.

While Healthy Kids programs can (but rarely) span multiple counties, each program operates independently and partners with its own health plan(s), another important distinction from CaliforniaKids.

As noted above, children are eligible for CaliforniaKids or Healthy Kids only if they are *ineligible* for full benefit coverage through the statewide programs, Medi-Cal and Healthy Families. Together, these two statewide programs provide coverage to U.S. citizen children and certain documented immigrant children from families with incomes below 250 percent of the FPL. While the two programs differ in copayments and certain types of benefits, both Medi-Cal and Healthy Families provide coverage for a full scope of health care services, including outpatient medical care, dental care, prescription drugs, mental health services, emergency department (ED) visits, and inpatient hospital stays.

Children on CaliforniaKids or Healthy Kids may be eligible for either of two statewide "limited benefit" coverage options that are available to low-income children. The first is a limited-scope benefit within Medi-Cal, known as emergency Medi-Cal, which provides coverage to children who meet Medi-Cal's income requirements but fail to meet its immigration requirements (or certain other eligibility rules). In contrast to the full benefit version of Medi-Cal, children on emergency Medi-Cal receive coverage only for emergency-related services, including necessary visits to an ED and inpatient hospital stays. For children enrolled in CaliforniaKids, emergency Medi-Cal is the main means of coverage for inpatient hospital care, making it a valuable source of insurance. For children enrolled in Healthy Kids, emergency Medi-Cal is largely incidental; children may have this coverage, but they would not be expected to use it since Healthy Kids already covers them for inpatient care.

A second limited benefit program, known as California Children's Services (CCS), provides coverage to children in California with severe medical problems such as cancer, diseases of the heart or other organs, blindness, and many others.[4] Children on Medi-Cal and Healthy Families are automatically eligible for CCS if they have a medical condition that qualifies; other children must meet family income requirements and complete an application. CCS covers children for all medical services related to their condition, as well as case management services and certain therapy services available in school.

MAJOR QUESTIONS EXAMINED BY THIS STUDY

This study addresses three sets of questions that may arise as policymakers in California consider how best to expand coverage to low-income children in the state:

1. ***Features of CaliforniaKids and Healthy Kids.*** What are the key features of the two local program types, such as their cost-sharing, provider reimbursements, and networks? To what extent do these features vary between

[4] For full information on CCS eligibility and coverage, see [http://www.dhs.ca.gov/pcfh/cms/ccs/].

or within the two program types (that is, within the individual CaliforniaKids programs, or within the individual Healthy Kids programs)?

2. ***Use of Services by Low-Income Children with Subsidized Coverage.*** How does children's use of health care on CaliforniaKids and Healthy Kids compare with use among children on the two statewide (benchmark) programs, Healthy Families and Medi-Cal? Are meaningful differences evident between the two local program types?

3. ***Typical Experience Accessing Inpatient (and Other High Cost) Care.*** For parents of a child with a significant health care need, such as a medical emergency, how would they typically navigate the health care system (at intake, discharge and referral) while covered by one of the local programs? To what extent does this experience vary either between or within the two local program types?

Below, we summarize the methods used to examine these questions. This is followed by a discussion of our findings and ideas about how more might be learned to address these questions. These include ideas for improving or expanding available data and for possible extensions to this study.

METHODS

USE OF SERVICES BY LOW-INCOME CHILDREN

We relied on six main data sources to examine the utilization of health care services among low-income California children with subsidized health insurance coverage (see Table 2).[5] These sources—which include household survey data and HEDIS data (derived from local health plan administrative data)[6]—reflect the most reliable information that is readily available for exploring utilization patterns of children on subsidized coverage programs in the state. They include (1) a 2003–2004 survey of Santa Clara Healthy Kids enrollees, (2) a 2002 survey of Healthy Families and Medi-Cal enrollees, (3) the 2005 California Health Interview Survey (CHIS), (4) 2005 HEDIS data collected on Healthy Kids children from the health plans in up to nine counties, (5) 2005 HEDIS data collected on Healthy Families and Medi-Cal children from these same health plans; and (6) 2006 HEDIS data collected for children in the Orange County CaliforniaKids program.

From these data, we constructed five measures of children's utilization on subsidized coverage programs. They include whether a child had (1) any medical/provider visit, (2) any well-child visit, (3) any dental visit, (4) any ED visit, and (5) any hospitalization. All measures reflect either a 6- or 12-month time frame. (Estimates based on HEDIS data are for 12 months, while those based on survey data are a mix of the two time frames.)

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[5] We explored several other data sources for this analysis but did not include them in our summary tables because they either focused on a relatively narrow (or otherwise poorly comparable) subpopulation or they are believed to be less reliable. Estimates from these sources are included in Appendix A as part of a series of supporting tables.

[6] HEDIS refers to the Healthcare Effectiveness Data and Information Set, a tool developed by the National Center for Quality Assurance (NCQA) to measure health plan performance across key dimensions of health care and service. The full HEDIS tool consists of 71 measures across 8 domains of care (including measures for adults). This study has available just four measures, which have been constructed from administrative data on children enrolled in the different types of coverage programs. (One of the four measures, on emergency department use, is actually derived from a broader HEDIS measure of children's ambulatory care use). The HEDIS data for the two local program types, Healthy Kids and CaliforniaKids, have not been audited for accuracy or completeness, a step that is normally taken to validate the HEDIS tool.

Table 2. Main Data Sources for Comparing Health Care Use by Low-Income Children on Subsidized Coverage Programs in California

Data Source	Insurance Program	Population	Type of Data	Year
Survey of Healthy Kids Enrollees in Santa Clara County	Healthy Kids, Santa Clara County	Continuously enrolled for one year	Survey	2003-2004
Congressionally Mandated Survey of SCHIP Enrollees and Disenrollees in 10 States	Healthy Families and Medi-Cal, statewide	Continuously enrolled for five months, Latino	Survey	2002
California Health Interview Survey	Healthy Families and Medi-Cal, statewide	Enrolled at a point in time, Latino	Survey	2005
Health plan data from insurance programs in nine counties[a]	Healthy Kids, selected counties	Continuously enrolled for one year	HEDIS[b]	2005
Health plan data from insurance programs in nine counties [a]	Healthy Families and Medi-Cal, selected counties	Continuously enrolled for one year	HEDIS[b]	2005
Health plan data from CaliforniaKids programs	CaliforniaKids, Orange County	Continuously enrolled for one year	HEDIS[b]	2006

HEDIS = Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service.

[a]The nine counties from which HEDIS data were collected were: Kern, Los Angeles, Riverside, San Bernadino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Santa Cruz. While HEDIS data were gathered from programs in all counties with a Healthy Kids program, only counties in which the sample size was large enough (greater than 30) were included in the calculations for each measure of utilization.

[b]The term "HEDIS" is used to describe these data because they have been constructed (from health plan data) following HEDIS guidelines. The data in this report differ from the complete HEDIS tool, however, in two important respects. First, they include only a subset of the measures related to children's access to care and service use that are included in the complete HEDIS tool. Second, the HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally taken to validate the HEDIS tool.

Except as noted in Appendix A, we limited the target population for these measures to children of Latino ethnicity who had been enrolled continuously in a given coverage program for at least one year. These limitations improve the comparability of the measures across programs. This is particularly true of comparisons between the two statewide programs (Medi-Cal and Healthy Families), which serve as benchmarks of utilization and access among low-income California children, and the two local programs that are the focus of this study (CaliforniaKids and Healthy Kids). In addition, to further refine these comparisons, we break down the rates for each measure by age groups. These age groups vary by the data source; estimates based on survey data are usually presented as three age groups (1 to 6 years old; 7 to 11 years old; and 12 to 19 years old), while estimates based on HEDIS have from two to four age groups, depending on the measure.

For each of the five measures, we compiled a detailed table summarizing the estimated rates of utilization across the programs based on all the supporting data we could identify

(not only the six main sources summarized in Table 2). In addition, we created what we believe is a more reliable set of three summary tables—comparing the estimated rates of medical care, dental care, and emergency and inpatient care, respectively—based on our six main sources. Findings on children's utilization, presented in the next chapter, focus on these three summary tables. (We have included the five measure-specific tables in Appendix A.)

FEATURES AND EXPERIENCES UNDER DIFFERENT COVERAGE PROGRAMS

We followed a three-step process for compiling information on the features of the different coverage programs and the typical experience of a child accessing care across them. In the first step, we reviewed all the local programs that offered coverage through either CaliforniaKids or Healthy Kids and chose a subgroup of six programs in which to conduct our comparative analysis. For CaliforniaKids, we chose the programs in Marin and Orange counties; and for Healthy Kids, we chose the programs in Los Angeles, San Francisco, Santa Clara, and Solano counties. We chose these programs because they account for a large fraction of the children enrolled by the two program types; for example, the local Orange County program accounts for about 58 percent of the CaliforniaKids population, while the local Los Angeles County program accounts for roughly 44 percent of the Healthy Kids population. In addition, we chose the programs because their respective counties are geographically diverse, reflecting a mix of highly urban and relatively rural sections of the state in both northern and southern California.

Having selected these six programs, we next developed a pair of program-specific tables that could be used to draw comparisons across them. The first of these tables centers on the key characteristics of a given local program, including its funding, eligibility, benefits, cost-sharing, network design, and provider payments. The second table focuses on a series of "use cases," describing how children with one of four different health conditions (an emergent health need, an elective surgery, a CCS-eligible condition, and a chronic illness) would access health care.[7] We selected these conditions, following the California HealthCare Foundation's guidance, because they are among the most potentially expensive health care conditions for children. For each of the six programs, we initially populated the tables from several available data sources, including local CaliforniaKids and Healthy Kids websites, health plan literature, existing research, and the study team's own knowledge about these programs.

As the third and final step in our data collection, we conducted a series of interviews during September through November 2007 with key informants in each of the six local programs. Given our short timeline and available resources, we conducted all interviews by phone with a small number of informants. For each program, we first interviewed a lead staff member with the program (or corresponding health plan) and then

[7] A "use case" is a tool commonly used by software and systems engineers to describe how an actor interacts with a system to achieve a goal. For this study, the actor is the enrolled child and the system is the health care system as it operates for the child's coverage program.

identified and interviewed one to three additional informants based on that member's recommendation or our own prior knowledge. We conducted the interviews in semi-structured format, using the two tables as a guide to walk informants through questions on the programs' characteristics and the ways in which children access care. During the interviews, we asked informants several questions about the overall experience of program enrollees and how it might differ from that of low-income children enrolled in other subsidized coverage programs, particularly Healthy Families. Following most interviews, we recontacted informants by email to gain clarification on particular topics that we had discussed and/or to obtain further information on specific questions.

Based on these interviews, we revised and expanded each of the local program tables. Then we constructed a pair of summary tables highlighting differences across the coverage programs in program characteristics and in the way a typical family navigates the health care system (the "use cases"). These two tables are included in the next section to support our discussion of the findings on cross-program features and the use cases.

CAUTIONS AND LIMITATIONS

Like any study that draws on descriptive and/or qualitative data to examine variations across programs, *findings from this study must be interpreted with caution.* In particular, to the extent that our data reveal important variations across programs, we cannot determine the source of these variations and we do not undertake any formal statistical testing that might imply we could. For example, variation in the use of services from survey data could arise because of differences in the exact wording of survey questions, the timing of the surveys, the populations that were sampled, or random variation in reporting. Or, alternatively, variation could arise because of actual differences between the programs or the populations that they serve—such as the characteristics of the children and families who enroll, the retention of these children, the availability of providers, or the requirements for cost-sharing or other specific program features—none of which we are able to isolate empirically.

Given these limitations, our conclusions in this study are based on a much less rigorous standard of evidence; namely, our own assessments based on experience and available literature, and the perspectives of key informants. In turn, while we may conclude from our data that a certain program feature (for example, coverage for inpatient services) is associated with variation in children's access to health care services, we are careful not to state that the feature *caused* this variation. Making such a statement requires a far more rigorous, and more challenging, research design that is beyond the scope of this study.

Two specific limitations of the utilization data should also be noted. First, our estimates of children's health care use rely on several different data sources, and each of these sources has its own underlying methodology that might easily produce variation in estimated health care use that is unrelated to the programs. Take, for example, the potential for variation between administrative and survey data sources. On the one hand, administrative data may not capture all aspects of care delivered; for instance, a child may receive well-child care in the context of a sick care visit. In addition, these data may be subject to missing information because providers fail to submit information on all services children received. On the other

hand, survey data are subject to bias due to errors in recall or social desirability (parents may want to appear responsive to their children's health care). In general, such differences would lead the utilization rate for a typical measure (such as well-child visits) to be lower when based on administrative data than when based on survey data, though variation in either direction is possible. As a result, particular caution must be used when drawing inferences of utilization rates between these two types of data.

Second, despite our use of multiple data sources, we have limitations in the measures themselves. No statewide survey or HEDIS data are available for Healthy Kids enrollees, leading us to draw on data for selected counties only.[8] Moreover, no survey data are available at all for CaliforniaKids, while the HEDIS data are based only on Orange County. Estimates for inpatient hospitalization are further limited; there are no HEDIS data available on inpatient stays for children on any of the programs, leading us to base our findings solely on survey data for three of the programs.[9] Finally, no data are readily available on other measures of interest, such as prescription drug use, access to a medical home, measures of care continuity, or preventable hospitalizations. While we made some inquiries about obtaining some of these data from individual health plans, the resources to clean and compile these data in order to make meaningful comparisons proved beyond this study's scope.

[8] One important statewide survey source, the California Health Interview Survey (CHIS), asks about children's insurance status but does not include a separate response category for either Healthy Kids or CaliforniaKids. This limitation greatly reduces the value of the CHIS for this study.

[9] California's Office of Statewide Health Planning and Development (OSHPD) collects information from licensed hospitals in the state on inpatient stays through a standardized reporting form. However, the form includes no insurance identifiers for CaliforniaKids or Healthy Kids, making it of little use for this study. We explored other sources of administrative data on inpatient hospitalizations but received data for only a few programs and were uncertain about data quality. We therefore included these data in the supporting appendix table (Table A.5) but not in the summary table presented in the main body of the report.

FINDINGS

FEATURES OF THE LOCAL (CALIFORNIAKIDS AND HEALTHY KIDS) PROGRAMS

The features of the CaliforniaKids and Healthy Kids programs vary along a number of dimensions (see Table 3). Among these features are their funding sources, eligibility rules, benefits, cost-sharing, network design, and provider payments. As described below, the variation in program features likely contributes to differences in the total premiums between the two programs, though it is not possible to determine which source of variation contributes more or less.

Funding. In all counties, CaliforniaKids and Healthy Kids programs rely on local funding, including support from a variety of county-specific organizations. Funding for CaliforniaKids includes contributions that are channeled through the CaliforniaKids Health Care Foundation.[10] Funding for Healthy Kids is somewhat broader, including support from a variety of public and foundation sources and private donations. The Santa Clara, Solano, and San Francisco Healthy Kids programs all receive county tobacco settlement monies. Solano also has a county matching fund, whereby private contributions are matched from county general revenue funds. In addition, state and local First 5 agencies are a major source of funding for covering Healthy Kids children ages 0 to 5.

Despite these many sources, funding remains below the level needed to meet demand and long-term sustainability of funds from existing sources is a major concern (Stevens et al. 2007). Currently, constraints in funding have forced many counties to establish enrollment caps and waiting lists.[11] The Santa Clara County Healthy Kids program, for example, has broad- based support in the county and receives funding from numerous sources. Yet, it

[10] The CaliforniaKids program in Marin County also receives county funding to provide additional dental coverage to children ages 6–18.

[11] In a recent study of the 25 California counties with Healthy Kids programs, Stevens et al. (2007) found that 15 of the programs (or 60 percent) had waiting lists. All of these counties had waiting lists for children ages 6–18, and 4 of them also had waiting lists for children ages 0–5. (Coverage for children ages 5 and under is usually provided by First 5 funds.)

Table 3. Summary of the Features of the CaliforniaKids and Healthy Kids Programs

Feature	Description
Program Funding	CaliforniaKids funding is mainly through the CaliforniaKids Health Care Foundation. Healthy Kids funding is broader, including a mix of county-based, foundation, and other public and private sources.
Program Eligibility	Eligibility requirements are similar for both program types, except that Healthy Kids covers children in families up to 300 percent of the FPL (and 400 percent of the FPL in the San Mateo County program) while CaliforniaKids covers children in families up to 250 percent of the FPL. Children under age 2 are also not eligible for CaliforniaKids. Children in both programs may be enrolled in emergency Medi-Cal. For CaliforniaKids, enrollment in Medi-Cal is often facilitated to cover inpatient services. For Healthy Kids, enrollment in emergency Medi-Cal may be incidental.
Health Plan Benefits	CaliforniaKids offers comprehensive benefits, with the exception of inpatient services, which are not covered, and certain outpatient emergency visits. Healthy Kids offers full range of comprehensive benefits, mirroring those of Healthy Families.
Premiums	With the exception of Marin County (which has no premium), CaliforniaKids premiums are higher than Healthy Kids and do not vary by family income. (Orange County, which has the largest program, has a premium of $15 per month; the two other sizeable programs, in Monterey and San Diego Counties, have premiums of $25 per month.) Healthy Kids premiums range from $0 to $15 per child depending on the county; most families pay the lower end of this range and have access to a hardship fund to subsidize the premium, if needed.
Co-payments	CaliforniaKids has higher copayments than Healthy Kids for some services (for example, $50 versus $5 for ED visits; $25 versus $5 for outpatient hospital services; and $5 versus $0 for preventive medical). Copayments for non-preventive office visits, including specialist visits, are the same for both programs ($5). Healthy Kids has no copayments for inpatient services. CaliforniaKids does not cover these services.
Network Design	Networks in both CaliforniaKids and Healthy Kids are generally the same as those of children on other subsidized coverage programs served by the local health plan. For CaliforniaKids, primary care is delivered primarily at community clinics; for Healthy Kids, primary care is provided at a broader range of sites, typically mirroring the options available to children on Healthy Families. In a few CaliforniaKids and Healthy Kids counties, programs have expanded their dental or mental health networks to serve the target population.
Provider payments	For CaliforniaKids, provider payments are nearly always capitated in all county programs. For Healthy Kids, most programs also capitate services, though there are exceptions. For example, the Solano County Healthy Kids program reimburses providers on a fee-for-service basis. Hospitals under managed care contracts are paid on a per diem basis.

Sources: County-specific health plan literature accessed by internet (see report references); interviews with the CaliforniaKids executive director and staff in Marin and Orange counties; and Healthy Kids Health Plan staff in Los Angeles, San Francisco, Santa Clara, and Solano counties (September through November 2007).

Notes: See Appendix B for a summary of the features for each local program.

currently has had to limit new enrollment among children over age five in response to funding constraints. This has resulted in a lengthy waiting list of families interested in enrolling, which the program maintains. CaliforniaKids does not maintain a formal waiting list in any of its local programs. This does not mean, however, that the programs are able to serve all eligible families who would like to participate.

Program Eligibility. Eligibility is slightly different between the two program types. The main difference is that CaliforniaKids covers families up to 250 percent of the FPL, while Healthy Kids normally covers children up to 300 percent of the FPL (one program, San Mateo County Healthy Kids, covers children up to 400 percent of the FPL). A second difference is that CaliforniaKids does not cover children under age 2. While other factors, such as outreach or cost-sharing requirements (see below), may affect who enrolls and remains in the different local programs, this variation in program eligibility appears to have little affect. According to program staff, most children enrolling in both program types live around or below the poverty level and qualify for these programs because they have undocumented immigration status (which tends to make them older than age 2). Thus, most children enrolling in either CaliforniaKids or Healthy Kids would have been eligible for the other program type (barring budget constraints) had it been available in their county instead.

Benefits and Cost-Sharing. Both CaliforniaKids and Healthy Kids offer comprehensive outpatient benefits, including medical, dental, vision, prescription, and mental health benefits.[12] CaliforniaKids does not cover any inpatient services; children are referred to Medi-Cal for inpatient care. Healthy Kids covers both outpatient and inpatient care, and the benefits typically mirror those of Healthy Families.

With the exception of its program in Marin County (which has no premium), CaliforniaKids generally has higher premiums than Healthy Kids. Its largest program, in Orange County, has a premium of $15 per month; most other counties have a $25 per month premium. CaliforniaKids premiums also do not vary by income, whereas Healthy Kids programs have a sliding scale that allows families near or below the poverty level to pay little or no premium.[13] We found some evidence that these differences in premiums are associated with differences in retention. For example, the CaliforniaKids program in Orange County reported that enrollment dipped when they increased the premium (but has since remained stable). In contrast, its program in Marin County reported having the highest retention of any of the CaliforniaKids counties. Among the four Healthy Kids programs we studied, all had funds available for premium assistance (if needed) and none indicated that inability to pay the premium was a barrier to retention.

Neither program type has copayments for preventive medical care and both have copayments of $5 for non-preventive medical visits. For other services, CaliforniaKids tends

[12] CaliforniaKids provides only limited coverage for outpatient ED care.

[13] Most Healthy Kids families have income below the FPL and therefore pay little or no premium. For example, health plan staff in Los Angeles reported that about 88 percent of their enrollee population fell into the lowest income bracket, and as a result paid no premium.

to have higher copayments than Healthy Kids. For example, CaliforniaKids has a $50 copayment for outpatient ED visits, whereas Healthy Kids programs have a $5 copayment for these visits.[14] CaliforniaKids also has higher copayments for outpatient hospital services, $25 compared with just $5 for Healthy Kids. Copayments can also vary within program types. For example, the CaliforniaKids program in Marin has no copayments for most types of dental care, while most of the other programs have copayments for all dental services. Likewise, most Healthy Kids programs have no copayments for preventive dental care, but they have varying copayments for other types of dental services. No information is available on whether or how these differences in copayments might affect enrollment or retention across the local programs.

Network Design. Children on CaliforniaKids receive care through the provider networks of Blue Cross. Children on Healthy Kids typically receive care through a single health plan, though the plan varies by county. In most counties, this health plan also provides Healthy Families and Medi-Cal coverage. The one exception for this study is Solano County, which offers Healthy Kids coverage through the Partnership HealthPlan. This plan covers Medi-Cal children, but it does not cover Healthy Families children. (Blue Cross is the main Healthy Families health plan in Solano County.)

In most counties, CaliforniaKids has a smaller provider network than Healthy Kids. While children in both programs typically receive care from providers at community clinics, children on Healthy Kids normally have other options available, including at least one private physician network. (These options generally mirror those of Healthy Families children.)

Both CaliforniaKids and Healthy Kids contract out health care for dental, vision, and mental health services. In some counties, these contracts may provide children enrolled in the local programs with better access to health care than children on the statewide programs, including Healthy Families. In Los Angeles, for example, Healthy Kids children with severe mental health conditions receive care through a contract with the local health plan (LA Care) established with mental health specialists at PacifiCare Behavioral Health (PBH). In contrast, Healthy Families children with severe mental health conditions receive care through the county mental health department, which (according to staff at LA Care) affords children with far less access to mental health care because the county network is significantly smaller than the PBH network. Likewise, in Marin County, the health plan for CaliforniaKids broadened its network of dental and mental health providers in response to concerns that the existing network lacked culturally competent providers. This expanded network mirrors Healthy Families but is broader than the one for children on Medi-Cal.

For children with severe health care needs, the plans in both local program types try to facilitate enrollment into the state CCS program, in some cases providing direct assistance with the application process. Programs do this both because of the high cost of care for

[14] Most Healthy Kids counties have a $5 copayment for ED visits; however, San Francisco County has a $15 copayment for such visits.

these children and the opportunity to have CCS-specific providers better coordinate the children's care. Enrolling in CCS often presents a relative challenge to families with children enrolled in either local program type because they must establish not only medical and residential eligibility but also financial eligibility. (In contrast, a statewide memorandum of understanding between CCS and Healthy Families waives the need to establish financial requirements.)[15] As incentive for families to enroll children with a CCS-eligible condition, health plans often will not pay for CCS-eligible services if the family has failed to apply for coverage.

Provider Payments. CaliforniaKids typically reimburses providers through a capitated payment, placing the providers "at risk" for the child's health care costs. Most Healthy Kids programs, including the two largest programs evaluated for this study (Los Angeles and Santa Clara), also reimburse most providers through a capitated rate. In Los Angeles, most primary care providers are paid through a third party intermediary. The most common exception to this standard of capitation is for specialists.

Total Premiums. CaliforniaKids has lower total premiums than Healthy Kids, though Healthy Kids' premiums have trended down in recent years in at least some local programs. Based on data available at the time of this study, we estimate that the total per-member per-month premium for CaliforniaKids is around $53 across the counties.[16] This is lower than recent estimates for Healthy Kids, which place the average premium across the counties at around $94 for children ages 0 to 5 and at $86 for children ages 6 to 18 (Stevens, Cousineau, and Rice 2007). It is likewise lower than the figure we obtained for three of the Healthy Kids programs featured in this study—$74 in Los Angeles, $97 in Solano County, and $135 (ages 0 to 5) and $76 (ages 6 to 18) in Santa Clara.

Lacking data on the actual costs of the local programs, this study cannot determine how accurately these differences in total premiums translate into differences in costs. Nor can it isolate which factors have contributed to the variation seen in premiums, either between or within the two coverage types. Findings do suggest, however, that the relatively low premiums for CaliforniaKids are not merely a function of excluding coverage for inpatient care. Of three Healthy Kids counties that provided an estimate of the proportion of costs that went to inpatient care, Solano County was the highest at just 12 percent. While further work is needed to assess the quality of this information, these initial estimates suggest that other factors, beyond the exclusion of inpatient coverage, are responsible for the CaliforniaKids' lower premiums. Examples of these possible factors include higher cost-sharing or subsidies for the program, differences in administrative costs, smaller (community

[15] At least one county Healthy Kids program, Los Angeles, established a county-specific memorandum of understanding with CCS, which gives them more leverage to work with providers and the county CCS office to enroll eligible children in the program. However, Healthy Kids families still must prove their financial eligibility to enroll in CCS.

[16] Marin and counties north of Marin pay an additional $8 per month beyond the standard $53 average monthly CaliforniaKids premium for enhanced dental benefits—specifically, to allow for an expanded network of dental providers and for families to not have copayments for dental services.

clinic-based) provider networks, more limited access for certain services (such as mental health care), and possibly lower capitation to providers.

USE OF SERVICES BY LOW-INCOME CHILDREN ON SUBSIDIZED COVERAGE PROGRAMS

Based on our review of available data, we find that children on all four subsidized coverage programs examined—CaliforniaKids, Healthy Kids, Healthy Families, and Medi-Cal—follow an expected pattern of health care. In each program, a sizable fraction of children use outpatient health care while few use inpatient health care.

The survey and HEDIS data suggest different conclusions about patterns of use across the four programs. Data from survey-based sources indicate that health care use is generally similar across all four programs. In contrast, when rates from HEDIS data are compared, health care use among children is typically lower in the local programs (CaliforniaKids and Healthy Kids) than in the statewide programs (Healthy Families and Medi-Cal). This pattern from the HEDIS data is evident not only for outpatient medical care but also for emergency department (ED) visits, making it difficult to conclude that it is due to differences in children's access to care. Indeed, given that the survey data seem no less reliable than the HEDIS data for making cross-program comparisons, there is no consistent evidence whether or not children's use of health care differs substantially between the local and statewide programs.

Additional data, coupled with a more rigorous research design that can control for differences in the populations being served and other factors, are needed before drawing defensible conclusions on how (and whether) children's utilization varies by insurance type.

Medical Visits. Survey data indicate similar use of outpatient medical care across the different types of insurance programs in the state (Table 4).[17] For example, among children ages 1 to 6, 66 percent of children on Healthy Kids were reported to have had a medical provider visit in the last six months compared with 65 and 66 percent on Healthy Families and Medi-Cal, respectively. Rates for children ages 7 to 11 are likewise nearly identical across the three programs, around 55 percent. For older children, ages 12 to 18, rates are somewhat lower for Healthy Kids than for the two statewide benchmark programs (43 percent for Healthy Kids versus 50 and 51 percent for Healthy Families and Medi-Cal, respectively).

In contrast to the survey data, HEDIS data show much higher rates of medical use among children on the statewide benchmark programs, Healthy Families and Medi-Cal, than among children on the local programs. Looking at medical visits in the past year, for example, utilization rates for children under age 7 are quite high—93 percent in Healthy Families and 84 percent in Medi-Cal—and both exceed the rates for either CaliforniaKids or

[17] No survey data are available for CaliforniaKids, so any comparisons made from this source are limited to three programs (Healthy Kids, Medi-Cal, and Healthy Families). For a more detailed summary of the estimated utilization rates by type of service, see Appendix A.

Healthy Kids (79 and 66, respectively). This pattern is likewise evident for measures of well-child visits; HEDIS rates in the state benchmark programs consistently exceed those in the local programs, often by 20 percentage points or more.

We are uncertain why the HEDIS data, but not the survey data, show such substantial variation between the local and statewide programs. Nor can we determine which is more likely to be correct. While the methodologies of the two sources obviously differ, there is little reason to expect those differences would lead the rates for the statewide programs to differ from the local programs for one source and not the other.

Table 4. Use of Outpatient Medical Care Among Low-Income Children in California, by Type of Subsidized Insurance Coverage

		Insurance Type			
Source	Age Range	CaliforniaKids Programs	Healthy Kids Programs	Healthy Families	Medi-Cal
Any Medical Visit (Past 6 Months)					
Survey Data	Ages 1-6	NA	66%	65%	66%
	Ages 7-11		55%	55%	56%
	Ages 12-18		43%	50%	51%
Any Medical Visit (Past Year)					
Survey Data	Ages 1-6	NA	NA	96%	96%
	Ages 7-11			84%	84%
	Ages 12-19			79%	79%
HEDIS[a]	Ages 1-6	79%	66%	93%	84%
	Ages 7-11	85%	NA	NA	NA
	Ages 12-19	80%	NA	NA	NA
Any Well-Child Visit (Past 6 Months)					
Survey Data	Ages 3-6	NA	55%	52%	53%
	Ages 12-18		34%	34%	33%
Any Well-Child Visit (Past Year)					
Survey Data	Ages 3-6	NA	NA	83%	79%
	Ages 12-17			79%	75%
HEDIS[a]	Ages 3-6	60%	57%	79%	80%
	Ages 12-21	38%	26%	52%	41%

Source: Data are drawn from several different sources; see Appendix Tables A.1 and A.2 for full details.

Notes: Estimates reflect a variety of time frames, populations and methods of data collection. As a result, caution should be used in interpreting differences (or no differences) in these estimates across the coverage types, and no formal tests have been conducted to determine the statistical significance of these differences (which would imply a level of rigor not afforded by these data).

[a]The term "HEDIS" is used to describe these data because they have been constructed (from health plan data) following HEDIS guidelines. The data in this report differ from the complete HEDIS tool, however, in at least two important respects. First, they include only a subset of the measures related to children's access to care and service use that are included in the complete HEDIS tool. Second, the HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

HEDIS = Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service.

NA = not available.

Comparisons between the two local programs are problematic because HEDIS data are limited to just a handful of age groups and have not been validated in the same manner as for the statewide programs. These data show a pattern of somewhat higher use among children on CaliforniaKids, but the limitations of the data recommend that no conclusions be drawn from this variation. For children under age 7, 79 percent of children on CaliforniaKids are estimated to have had a medical visit in the past year based on HEDIS, and 60 percent of these children are estimated to have had a well-child visit. Among children on Healthy Kids, the comparable HEDIS rates are 66 percent for any medical visit and 57 percent for well-child visits.

Dental Visits. Comparison of dental care use between the local and statewide programs is confined to survey data, a significant limitation given the inconsistency in the HEDIS- and survey-based comparisons with respect to medical visits. As with medical visits, the survey data on dental use show similar rates across the programs (Table 5). Indeed, to the extent any variation is evident, it tends to favor the local programs. For example, among older teens (15 to 18 years of age), 57 percent of Healthy Kids children are reported to have had a dental visit in the past six months compared with roughly 50 percent of children in the two state benchmark programs. This pattern could reflect pent up demand for dental services among children on the local programs, most of whom have previously lacked access to dental coverage in the past. However, as with the other results in this section, we cannot test this hypothesis or even determine with confidence whether this variation between the programs is real.

Within the two local program types, the pattern of dental care use is inconsistent. For example, children ages 7 to 10 have a lower reported rate of dental care use in the past year on CaliforniaKids than Healthy Kids (64 percent versus 74 percent); however, children ages 11 to 14 show almost the exact opposite pattern (75 versus 63 percent).

ED and Inpatient Visits. Comparisons of the local and statewide programs for ED and inpatient visits show a similar pattern to medical visits (Table 6). Namely, survey data show little difference across the programs, while HEDIS data indicate higher use (particularly of ED visits) among children on the statewide programs. For example, looking at survey data, 15 percent of children ages 6 to 18 on Healthy Kids were reported to have had an ED visit in the past six months compared to 13 percent of children in this age range on the two statewide programs. By comparison, HEDIS data for CaliforniaKids and Healthy Kids children had estimated utilization rates of 13 and 9 percent in the past year, and Healthy Families and Medi-Cal children had rates roughly twice as high—18 and 25 percent, respectively. Data for inpatient care are scant, though available data suggest use is low in all programs for all age groups. Available estimates range from less than 1 percent to 5 percent (in a six-month period).

As with the data on medical care use, we do not know the source of persistent variation in ED use between the survey- and HEDIS-based measures. Nor do we know which of these measures is more reliable for understanding cross-program variation. While the HEDIS data might be presumed to be more reliable because they are not self-reported, the completeness or quality of these data have not been verified for the local programs. In

addition, survey data are based on similarly worded questions and focus on similar groups of children (most often Latino children in the same age ranges who had been continuously enrolled in a given program for at least one year). Thus, while respondents to the surveys might make errors in recall, we have little reason to expect such errors would differ substantially across programs.

Table 5. Use of Dental Care Among Low-Income Children in California, by Type of Subsidized Insurance Coverage

		Insurance Type			
Source	Age Range	CaliforniaKids Programs	Healthy Kids Programs	Healthy Families	Medi-Cal
Any Dental Visit (Past 6 Months)					
Survey Data	Ages 4-6	NA	71%	66%	65%
	Ages 7-10		69%	72%	71%
	Ages 11-14		63%	59%	62%
	Ages 15-18		57%	51%	48%
Any Dental Visit (Past Year)					
Survey Data	Ages 4-6	NA	NA	81%	82%
	Ages 7-10			88%	89%
	Ages 11-14			NA	NA
	Ages 15-18			NA	NA
HEDIS	Ages 4-6	74%	72%		
	Ages 7-10	64%	74%		
	Ages 11-14	75%	63%		
	Ages 15-18	75%	59%		

Source: Data are drawn from several different sources; see Appendix Table A.3 for full details.

Notes: Estimates reflect a variety of time frames, populations and methods of data collection. As a result, caution should be used in interpreting differences (or no differences) in these estimates across the coverage types, and no formal tests have been conducted to determine the statistical significance of these differences (which would imply a level of rigor not afforded by these data).

[a]The term "HEDIS" is used to describe these data because they have been constructed (from health plan data) following HEDIS guidelines. The data in this report differ from the complete HEDIS tool, however, in at least two important respects. First, they include only a subset of the measures related to children's access to care and service use that are included in the complete HEDIS tool. Second, the HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

HEDIS = Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service.

NA = not available.

Table 6. Use of ED on Inpatient Care Among Low-Income Children in California, by Type of Subsidized Insurance Coverage

		Insurance Type			
Source	Age Range	CaliforniaKids Programs	Healthy Kids Programs	Healthy Families	Medi-Cal
Any Emergency Department Visit (Past 6 Months)					
Survey Data	Ages 1-5	NA	24%	20%	20%
	Ages 6-18		15%	13%	13%
Any Emergency Department Visit (Past Year)					
Survey Data	Ages 0-5	NA	NA	28%	22%
	Ages 6-18			14%	15%
HEDIS	Ages 2-9	13%	NA	NA	NA
	Ages 10-19	13%	NA	NA	NA
	Ages 0-5	NA	16%	27%	38%
	Ages 6-18	NA	9%	18%	25%
Any Hospitalization (Past 6 Months)					
Survey Data	Ages 1-5	NA	2%	5%	5%
	Ages 6-18		2%	1%	2%
Any Hospitalization (Past Year)					
Survey Data	Ages 1-5	NA	NA	NA	6%
	Ages 6-18				5%

Source: Data are drawn from several different sources; see Appendix Tables A.4 and A.5 for full details.

Notes: Estimates reflect a variety of time frames, populations and methods of data collection. As a result, caution should be used in interpreting differences (or no differences) in these estimates across the coverage types, and no formal tests have been conducted to determine the statistical significance of these differences (which would imply a level of rigor not afforded by these data).

[a]The term "HEDIS" is used to describe these data because they have been constructed (from health plan data) following HEDIS guidelines. The data in this report differ from the complete HEDIS tool, however, in at least two important respects. First, they include only a subset of the measures related to children's access to care and service use that are included in the complete HEDIS tool. Second, the HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

HEDIS = Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service.

NA = not available.

HOW CHILDREN WITH SIGNIFICANT HEALTH CARE NEEDS ACCESS CARE

As described in the methods section, we collected data on four "use cases" that were developed as a means to compare the experiences of children with significant medical

conditions as they accessed health care in selected local programs.[18] The illustrative conditions that we examined were: (1) an emergent health need, such as an appendicitis, that resulted in an emergency department visit and a subsequent inpatient hospital stay; (2) elective surgery, such as a hernia repair, that likewise resulted in a hospital stay; (3) a CCS-eligible condition, such as a heart or kidney problem; and (4) a chronic condition, such as asthma. For each condition, we examined where care would be delivered, how the family would navigate the system, and how care would be paid for.

Findings, based largely on interviews with health plan and other local program staff, indicate little variation in how families of children with significant health care conditions would typically access services across the local programs. This is true both between the two program types and within them. The exclusion of inpatient coverage under CaliforniaKids does require the use of separate insurance (emergency Medi-Cal) for care to be paid for, which can add to paperwork at admission. But respondents did not believe this exclusion typically affected outcomes beyond the admission process, including quality of care or post-discharge referrals. This perception is based solely on the perspective of key informants with local health plan/program staff, however, not with families themselves. Investigating this issue more rigorously, and more substantively, requires a research design that is beyond the scope of this study; for example, conducting a number of interviews with parents of children enrolled in different local programs (who have had a recent inpatient visit or with other types of emergent or elevated health care needs).

Children with Emergency or Inpatient Health Care Needs. The most notable variation reported by local health plan/program staff is in the use case of a child with an emergent health care condition (summarized in Table 7). This condition, illustrated by an appendicitis, results in the child visiting the emergency room, being admitted as an inpatient, and staying in the hospital overnight. Across all counties, families can take their child to any ED for this condition and receive treatment. However, families on CaliforniaKids may face more paperwork at intake if they have not previously enrolled their child in emergency Medi-Cal in order to cover this service. (For this reason, CaliforniaKids in Orange County encourages families to enroll in emergency Medi-Cal when they apply for CaliforniaKids).

Healthy Kids children should not face this extra step because the ED visit and subsequent inpatient admission are covered services. However, despite this coverage, evidence from our interviews suggests that some families, particularly in Los Angeles, may maintain concurrent coverage in emergency Medi-Cal and present that coverage instead upon ED admission (much as a CaliforniaKids family would). Alternatively, some families may fail to produce any insurance card, leading to the same extra step of obtaining emergency Medi-Cal coverage for the visit. In both of these cases, reimbursement for the child's inpatient stay would be handled by Medi-Cal, instead of Healthy Kids.

[18] Unless otherwise noted, our discussion of the findings from these use cases is based on the six county programs for which we conducted informant interviews (Marin and Orange for CaliforniaKids; Los Angeles, San Francisco, Santa Clara, and Solano for Healthy Kids).

Among health plan staff in the four counties serving Healthy Kids children, staff in Los Angeles were the only ones who believed that admission through emergency Medi-Cal might be prevalent.[19] Given the size of this county and the large number of hospitals a Healthy Kids child might visit, eliminating this confusion may be relatively challenging. Program staff in other Healthy Kids counties largely dismissed this issue. For example, in Santa Clara County, most children on Healthy Kids sought emergency care at a small number of hospitals in the programs' network and, at each of these hospitals, the health plan maintained a computerized system that determined each child's insurance status at intake.

No one whom we interviewed for this study believed that the type or quality of care would differ based on whether children were admitted to the ED or hospital through Healthy Kids, Healthy Families, or emergency Medi-Cal. However, we did receive some anecdotal evidence that care coordination could become more challenging for a child whose services were covered by emergency Medi-Cal. For example, a discharge planner at the hospital, not realizing that a child had coverage other than emergency Medi-Cal, might fail to inform the child's primary care provider (PCP) or to refer the family to the best available options for follow-up care (for instance, those the PCP would recommend).

Informants with CaliforniaKids believed that this problem did not arise very often and, even when it did, it typically resolved itself quickly. For example, upon discharge, the family would more than likely visit their PCP regardless of the discharge plan or would wind up visiting a local clinic provider who would identify their coverage and refer them appropriately. Information collected from parents could further inform this issue of childrens' referral experiences on the different programs; however, as noted, that research design is beyond the scope of this study.

Children with Other Significant Health Conditions. Across the six local programs examined in this study, we find little variation in how children with a chronic or otherwise serious health condition would access services. To the extent there is variation, it is associated most with the county's health care system and not with the coverage type.

For children with a CCS-eligible condition, each county has a group of providers who specialize in their care, and informants in all six counties reported no issues with the access CCS-eligible children had to these services. At the same time, knowledge of this issue appears limited given the small proportion of children served by CCS[20] and the fact that coverage is carved out for care related to their condition. For children with chronic

[19] A recent study found that 39 percent of Healthy Kids enrollees in Los Angeles County were concurrently enrolled in emergency Medi-Cal, and 10 percent of parents reported using their child's emergency Medi-Cal card at some point during their child's first year of enrollment (Sommers, Howell, and Hill 2007).

[20] Data from informants suggest that around 1 or 2 percent of enrolled children on the county programs are enrolled in CCS. Rates do not appear to vary notably across programs.

Table 7. How Families of Children with Emergent Health Care Needs Access Care Under CaliforniaKids Programs and Healthy Kids Programs

	CaliforniaKids Programs	Healthy Kids Programs
Where Care is Delivered	Child is taken to nearest hospital to be treated for emergency. Hospitals are not part of the CaliforniaKids network.	Child is taken to nearest hospital to be treated for emergency. Hospital may be either in-network or out-of-network.
Admission Process	CaliforniaKids does not cover inpatient services, requiring the family to have emergency Medi-Cal in order for the child's inpatient care to be covered. This can lead to two scenarios: 1. Child has emergency Medi-Cal coverage. Child is admitted and receives appropriate care. 2. Child does not have emergency Medi-Cal coverage (or any other qualifying coverage). Hospital staff facilitates emergency Medi-Cal application process, and child is admitted and receives appropriate care.	Inpatient care is covered by Healthy Kids. However, family may fail to present card and/or have emergency Medi-Cal, causing possible confusion. This can lead to two scenarios: 1. Child is identified as having Healthy Kids coverage, either by presenting proof of insurance or by local hospital's information systems. Child is admitted and receives appropriate care. 2. Child is not identified as having Healthy Kids coverage, leading hospital staff to facilitate emergency Medi-Cal application process (if not already covered). Child is admitted and receives appropriate care. Services are charged to Medi-Cal.
Care Coordination and Discharge Process	Hospital may or may not identify the child as having CaliforniaKids coverage or recognize the benefits it provides. This can lead to two scenarios: 1. Child is identified as having CaliforniaKids coverage, and hospital coordinates care (such as discharge planning) with child's PCP. 2. Child is not identified as having CaliforniaKids coverage, leading hospital to assume child has no insurance for medical care after discharge. PCP is not notified of hospitalization unless informed by the family, interfering with care coordination. Referral for follow-up care could be to local community clinic, where CaliforniaKids coverage is likely to be identified. If coverage is not identified, family risks increased out-of-pocket costs.	Hospital typically will have identified child's Healthy Kids coverage. However, a second scenario (similar to CaliforniaKids) can occur if this fails to happen: 1. Child is admitted under Healthy Kids, leading child's PCP to be notified of the emergency. Subsequent care is coordinated between PCP and hospital. 2. Child is admitted under emergency Medi-Cal, possibly leading hospital to assume child has no insurance for medical care after discharge. PCP is not notified of hospitalization unless informed by the family, interfering with care coordination. Referral for follow-up care could be to provider/clinic inside of child's network, where Healthy Kids coverage is likely to be identified. If coverage is not identified, family risks increased out-of-pocket costs.
How Care is Paid for	Copayment of $50 for emergency services is waived because the child is hospitalized. Hospital is reimbursed for inpatient stay by emergency Medi-Cal.	Copayment of $5 for emergency services is waived because the child is hospitalized. Hospital is reimbursed for inpatient stay by the child's health plan.

Sources: County-specific health plan literature accessed by internet (see reference list); interviews with the CaliforniaKids executive director and staff in Marin and Orange counties; and Healthy Kids Health Plan staff in Los Angeles, San Francisco, Santa Clara, and Solano counties (September through November 2007).

conditions, some local health plans have developed specialized programs, though their presence seems unrelated to the local program type. Solano County has a relatively high asthma rate among counties in the state and, in response, has developed a tailored program for coordinating its treatment. Typically, the PCP will diagnose the asthma condition and alert the health plan, whereupon the child is admitted to a special program that develops and monitors a treatment plan that has been individualized for the nature and severity of the condition.

IDEAS FOR FURTHER STUDY

As described previously, findings from this study are based on data collected and assembled from a variety of disparate sources that together provide a limited degree of rigor for comparing and contrasting children's utilization, access, and experiences across the different health care coverage programs. Below we present several ideas for how existing data might be improved to strengthen the evidence available for making these comparisons.

Ideas to Improve Available Utilization Data. In the coming months, additional utilization data on Healthy Kids programs will become available from both survey and administrative sources. Among these data are a new round of HEDIS data on selected Healthy Kids programs (collected and analyzed by researchers at the University of Southern California), and survey data on children's health care use in the Healthy Kids program in San Mateo County (collected by Mathematica Policy Research, Inc. and analyzed by researchers at The Urban Institute). One potential benefit of these data will be to better understand the inconsistency that currently exists between the estimates of children's health care use based on administrative and survey-based sources. Both sets of estimates are currently based on just a few observations—HEDIS estimates are based on a single round of data collection (the first ever compiled by many Healthy Kids health plans for this purpose), and survey estimates are based on data from just two Healthy Kids programs (Santa Clara County and, to a lesser extent, Los Angeles County). Once these additional data are made available, we may begin to find a more consistent story emerging with respect to utilization on Healthy Kids.

In addition to investigating these new sources, we propose three ideas for improving knowledge of children's health care use across the local programs. The first is to improve the information gathered from two major sources of regularly collected data in the state—CHIS and OSHPD. Currently, neither of these sources includes any coding to identify children enrolled in either Healthy Kids or CaliforniaKids, making it impossible to use these sources to develop estimates of utilization on these programs. While enrollment in these programs remains small relative to the statewide programs, the addition of a new insurance category to indicate Healthy Kids coverage (the larger program) may still provide a way to measure children's utilization on Healthy Kids throughout the state. This is particularly true

of OSHPD, which reflects a census of inpatient utilization in the state and thus does not suffer the problem of limited sample size that may severely affect the CHIS.[21]

A second approach is to conduct further followup with the health plans in order to determine what additional, high quality utilization data might be made available. To date, the ongoing work to gather HEDIS measures for Healthy Kids children is by far the most significant source of utilization data not based on a household survey. However, these data focus on a relatively small number of measures within the HEDIS tool and are not validated in the same manner as the data for the statewide programs. This study did not pursue administrative data from the local programs (to construct additional measures) because of the significant investment required to assess their quality and structure them in a consistent, comparable format. However, this request, and the subsequent steps to make the data comparable, could be carried out in a future study.

The third approach to improving the available data is to conduct a joint household survey of families with children on the programs. This survey could focus on families with a child enrolled in either Healthy Kids or CaliforniaKids across as many of the counties that these programs serve as possible. (The main constraint, at least in the case of Healthy Kids, is obtaining the contact data for the families from each county program). Given sufficient resources and necessary permissions from the state, this survey could also include children on Healthy Families programs, possibly drawing on contact data from the same county-based sources.

A major benefit of such a survey is that the data for all programs would be based on the same methodology. This would greatly improve the rigor of comparisons across the programs in two ways. First, it would eliminate concerns that any cross-program differences in the data were simply due to differences in methods. Second, it would allow for formal tests of whether the differences between the programs met statistical standards for significance (meaning that they were not simply due to chance). A further benefit of such a survey is that the questionnaire could probe far beyond basic information on utilization rates to examine numerous other questions. For example, the survey could examine what types of barriers children on subsidized coverage programs might be experiencing and why. Relatedly, it could uncover why some families do not appear to be taking advantage of core benefits of their coverage (for example, making well-child visits and seeking preventive dental care).

A household survey could also potentially oversample, or exclusively sample, key subgroups of children—for example, those with a recent ED visit or inpatient hospital stay, those enrolled in specialized programs (for example, for treatment of asthma), or those with

[21] Another difficulty with developing estimates from the CHIS is the low overall response rate on the survey—less than 30 percent in the last two rounds of data collection. This rate is most likely even lower for the predominant population served by the local programs (low-income, undocumented Latino families), making the accuracy of the estimates for this population particularly questionable. The CHIS also asks a fairly modest number of questions about children's use of services and the wording of these questions often varies substantially across the different survey waves, making it difficult to examine changes in rates over time.

notably high health care costs. Survey questions could also probe families' experiences accessing health care, including their perceptions of care quality or care coordination (for example, their experiences with discharge or referrals following post-acute care).

Ideas to Better Compare Children's Health Access (Use Cases). Information to better compare children's access can also be obtained by expanding the qualitative data gathered for this study. One approach is to expand the informant interviews to include a larger number of staff associated with the health insurance programs in the counties, particularly those who work in provider settings. Examples include nurses and other staff responsible for patient intake and care at either local health clinics or emergency departments that serve children on the programs, and discharge planners and other staff at hospitals most often frequented by children on the programs. Ideally these interviews could be conducted both in person and in small groups, to gain consensus views and facilitate productive interaction among informants.

An additional approach is to conduct interviews with focus groups of families with children enrolled in the local programs. Information gathered from these interviews could be similar to the types of data collected through probes on the household survey described above. For example, parents could be asked about any difficulties that they had faced accessing health care for their child and any difficulties that had taken place in coordinating care. As with the survey, sampling for the focus groups could be done for specific subgroups, such as children with chronic conditions or a recent inpatient hospital stay. A main advantage of the focus groups is cost; they require far fewer resources than completing a household survey. In addition, focus groups provide opportunities to probe in detail and to have families exchange and share perspectives, so the information gathered from them can sometimes be more detailed, or even more thoughtful, than information obtained from a survey. A main drawback with the focus group approach is that data are rarely representative; families who invest the time and effort needed to participate in the groups are often not reflective of all families on the programs. In addition, given the small sample size and lack of systematic data collection, focus groups do not offer a means to develop quantitative measures of access that can be examined most rigorously.

Ideas on Exploring Costs. One issue only touched on in this study is the cost of the programs. While we find evidence of a difference in the total premium between the two program types, we are uncertain about the reasons for this difference or whether it even reflects an actual difference in costs. Likewise, we are uncertain about the source of variation in premiums across the Healthy Kids programs. Developing a better understanding of these issues requires both the support and cooperation of the programs and the development of a careful research design that can isolate the role that different factors (demographics, region, provider networks, cost structure, benefits) have in determining costs. While no study can disentangle these factors completely, significant progress could be made with a more rigorous research design and local program support.

SUMMARY

Findings from this study indicate that children on two types of local health insurance programs for children in California, Healthy Kids and CaliforniaKids, have made substantial use of outpatient health care. While HEDIS data from selected counties suggest that children on these programs make less use of outpatient services than those on the statewide programs, they nevertheless show that these services are utilized by a sizable fraction of enrollees. (For example, in both local programs, HEDIS data indicate that roughly 60 percent of children under age 7 had a well-child visit in the past year.) Moreover, data from household surveys for Healthy Kids and those for Healthy Families and Medi-Cal are inconsistent with HEDIS, showing little or no difference in utilization across these programs.

Despite some variability in program structure, data from interviews with local health plan and program staff suggest that children with significant health care needs access services similarly on the local programs. Informants also saw little difference between the care available to the typical child on these programs and those on the statewide programs. Indeed, for certain services such as dental and mental health care, some local programs have increased the provider networks and improved access, particularly relative to Medi-Cal. Informants affirmed that the exclusion of emergency services under CaliforniaKids could potentially interfere with care coordination for children receiving emergency care; however, they did not believe this was a common barrier to care for the typical child. Informant interviews also suggested that higher premiums in some CaliforniaKids programs could contribute to less stable coverage, though additional research is needed to confirm this finding and to understand the extent to which any variation in retention is linked to differences in cost-sharing.

Several ideas exist for improving the quality, depth, and breadth of the findings presented in this study. Some, such as creating a new insurance category in OSHPD, are costless (beyond the resources needed to promote and execute the idea among its stakeholders). Others, such as conducting a household survey, are resource intensive but offer substantial opportunities to expand on this study. Among these potential improvements are a far better understanding of how health care use varies across the programs (and the populations that they serve), and more detailed, rigorous information on

specific subtopics, such as access to care and care coordination for children with special health care needs.

REFERENCES

California Department of Public Health, Children's Medical Services Branch. "California Children's Services." [http://www.dhs.ca.gov/pcfh/ cms/ccs/]. Accessed December 10, 2007.

CaliforniaKids Healthcare Foundation. "About CaliforniaKids and Summary of Benefits." [http://www.californiakids.org/aboutframe.html]. Accessed September 24, 2007.

CaliforniaKids Healthcare Foundation. "Our History, Our Experience, and Our Future." December 2006. [http://www.californiakids.org/history12-06.pdf]. Accessed September 24, 2007.

Cousineau, Michael R., Gregory D. Stevens, and Trevor Pickering. "Preventable Hospitalizations Among Children in California Counties after Child Health Insurance Expansion Initiatives." *Medical Care* (forthcoming).

Davidoff, Amy J., A. Bowen Garrett, Diane M. Makuc, and Matthew Schirmer. "Medicaid-Eligible Children Who Don't Enroll: Health Status, Access to Care, and Implications for Medicaid Enrollment." *Inquiry*, summer 2000, pp. 203-218.

Dubay, Lisa, and Genevieve M. Kenney. "Health Care Access and Use Among Low-Income Children: Who Fares Best?" *Health Affairs*, vol. 20, no.1. January/February 2001, pp. 112-121.

Howell, Embry, Lisa Dubay and Louise Palmer. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status." Washington, DC: The Urban Institute, June 2007.

Institute for Health Policy Solutions. "California's Family Health Insurance Programs." [http://www.ihps-ca.org/resources/_pdfs/CA_Fam_Health_Ins_Programs.pdf]. Accessed December 10, 2007.

Institute for Health Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/WebsiteTableDocument_040607.pdf]. Accessed September 24, 2007 .

Institute for Healthy Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/WebsiteTableDocument_011107_rev2.pdf]. Accessed April 1, 2007.

Institute for Health Policy Solutions. "Pioneers for Coverage: Local Solutions for Insuring All Children in California." [http://ihps-ca.org/technicalassistance/_pdfs/CHI_Guidebook_1104.pdf]. Accessed April 1, 2007.

L.A. Care Health Plan. "Healthy Kids Program Member Handbook 2005-2006, Combined Evidence of Coverage and Disclosure Form, July 1, 2005 to June 30, 2006." [http://www.lacare.org/opencms/export/download/members/08_LA0012_0705_HK_EOC_en.pdf]. Accessed September 28, 2007.

L.A. Care Health Plan. "L.A. Care's Healthy Kids Program." [http://www.lacare.org/opencms/opencms/en/members/programs/healthy_kids/index.html#diseasemanagementprogram]. Accessed September 28, 2007.

Mannanal, Jolly. "Directory of Local Efforts to Expand Healthcare Access for California's Uninsured." Insure the Uninsured Project, January 2007. Available at [http://www.itup.org/Reports/Solutions/Local%20Efforts%20Report%202006.pdf]. Accessed September 24, 2007.

National Health Foundation. "CaliforniaKids." 2006. [http://www.champ-net.org/training/manual/ch6.pdf]. Accessed April 1, 2007.

Newacheck, Paul W., Jeffrey J. Stoddard, Dana C. Hughes, and Michelle Pearl. "Health Insurance and Access to Primary Care for Children." *New England Journal of Medicine*, vol. 338, no. 8, February 19,1998, pp.513-519.

Partnership HealthPlan of California. "Healthy Kids Health Plan Combined Evidence of Coverage and Disclosure Form." [http://www.partnershiphp.org/Members/HK_EOC_EN.pdf]. Accessed October 30, 2007.

San Francisco Health Plan for Healthy Kids and Young Adults. "Combined Evidence of Coverage and Disclosure Form." Benefit Year July 1, 2007 to June 30, 2008. [http://www.sfhp.org/files/PDF/members/EOC/ 6027E_HKYAEOC_2007.pdf]. Accessed September 14, 2007.

Santa Clara Family Health Plan. "Combined Evidence of Coverage & Disclosure." Benefit Year July 1, 2005 to June 30, 2006. [http://www.scfhp.com/bp/All/Docs/EOC/HKEOCENG.pdf]. Accessed July 3, 2007.

Solano Coalition for Better Health. "Current Initiatives and Programs." [http://www.solanocoalition.org/initiativesprograms/initiatives.asp]. Accessed October 30, 2007.

Sommers, Anna S., Embry M. Howell, and Ian Hill. "Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data." Washington, DC: The Urban Institute, June 2007.

Stevens, Gregory D., Michael R. Cousineau, and Kyoko Rice. "Financial Sustainability of Healthy Kids Programs." Alhambra, CA: University of Southern California Center for Community Health Studies, August 2007.

Stevens, Gregory D., Michael R. Cousineau, Em T. Arpawong, and Kyoko Rice. "Functioning at the Brink: The Children's Health Initiatives Have Grown but May Not Survive." Alhambra, CA: University of Southern California Center for Community Health Studies, September 2007.

Trenholm, Christopher, Embry Howell, Dana Hughes, and Sean Orzol. "The Santa Clara County Healthy Kids Program: Impacts on Children's Medical, Dental and Vision Care: Final Report" Princeton, NJ: Mathematica Policy Research, Inc., July 2005.

Trenholm, Christopher, Embry Howell, Ian Hill, and Dana Hughes. "Three Independent Evaluations of Healthy Kids Programs Find Dramatic Gains in Well-Being of Children and Families. In Brief #1" Princeton, NJ: Mathematica Policy Research, Inc., November 2007.

Wooldridge, Judith, Genevieve Kenney and Christopher Trenholm. "Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress" Princeton, NJ: Mathematica Policy Research, Inc., October 2005.

APPENDIX A

SUPPORTING TABLES ON THE USE OF SERVICES BY LOW-INCOME CHILDREN IN CALIFORNIA

Table A.1. Measures of Service Use for Low-Income Children in California: Any Medical Visit

Insurance Program	Location	Population	Estimate[a]	Data Source
Any Medical Visit in Past 6 Months, Survey Data				
Healthy Kids	Los Angeles County	Enrolled one year		
		Ages 1–5	75%	b
	Santa Clara County	Enrolled one year		
		Ages 1–6	66%	c
		Ages 3–6	63%	
		Ages 7–11	55%	
		Ages 12–18	43%	
	Santa Clara County	Enrolled four years		
		Ages 4–6	63%	d
		Ages 7–11	61%	
		Ages 12–18	58%	
CaliforniaKids	Los Angeles County	Enrolled six months		
		Ages 2–18	32%	e
Healthy Families	Statewide	Latino		
		Ages 1–6	65%	f
		Ages 3–6	64%	
		Ages 7–11	55%	
		Ages 12–19	50%	
Medi-Cal	Statewide	Latino		
		Ages 1–6	66%	f
		Ages 3–6	65%	
		Ages 7–11	56%	
		Ages 12–19	51%	
Any Medical Visit in Past 12 Months, Survey Data				
Healthy Families	Statewide	Latino		
		Ages 1–6	96%	g
		Ages 3–6	95%	
		Ages 7–11	84%	
		Ages 12–19	79%	
	Los Angeles County	Latino		
		Ages 1–6	91%	
		Ages 3–6	89%	
		Ages 7–11	83%	
		Ages 12–19	72%	
Medi-Cal	Statewide	Latino		
		Ages 1–2	97%	g
		Ages 1–6	96%	
		Ages 3–6	94%	
		Ages 7–11	84%	
		Ages 12–19	79%	
	Los Angeles County	Latino		
		Ages 1–6	96%	
		Ages 3–6	94%	
		Ages 7–11	84%	
		Ages 12–19	80%	

Table A.1 *(continued)*

Insurance Program	Location	Population	Estimate[a]	Data Source
Any Medical Visit in Past 12 Months, Administrative Data				
Healthy Kids	San Mateo County	First year of enrollment Ages 0–18	 74%	 h
	Los Angeles County	First year of enrollment Age 0 Age 1 Ages 2–5 Ages 6–18	 67% 66% 61% 43%	 i
Healthy Families	San Mateo County	First year of enrollment Ages 0–18	 82%	 h
Medi-Cal	San Mateo County	First year of enrollment Ages 0–18	 77%	 h
Any Medical Visit in Past 12 Months, HEDIS Data				
Healthy Kids	Three counties	Ages 1–2	69%	j
	Los Angeles County		62%	
	San Francisco County		98%	
	Eight counties	Ages 1–6	66%	
	Seven counties	Ages 3–6	67%	
	Los Angeles County		52%	
	San Francisco County		89%	
	San Mateo County		76%	
	Santa Clara County		88%	
CaliforniaKids	Orange County	Ages 2–6 Ages 7–11 Ages 12–19	79% 85% 80%	k
Healthy Families	Statewide	Ages 1–2	92%	l
	Six counties		95%	j
	San Francisco County		100%	
	San Mateo County		97%	
	Santa Clara County		96%	
	Seven counties	Ages 1–6	93%	
	Statewide	Ages 3–6	87%	l
	Seven counties		87%	j
	San Francisco County		94%	
	San Mateo County		84%	
	Santa Clara County		86%	
Medi-Cal	Six counties	Ages 1–2	92%	j
	San Francisco County		94%	
	Santa Clara County		96%	
	Six counties	Ages 1–6	84%	
	Six counties	Ages 3–6	83%	

Table A.1 *(continued)*

Insurance Program	Location	Population	Estimate[a]	Data Source
	San Francisco County		84%	
	Santa Clara County		85%	
Any Medical Visit in Past 24 Months, HEDIS Data				
Healthy Kids	Six counties	Ages 7–11	68%	j
	Los Angeles County		56%	
	San Francisco County		85%	
	San Mateo County		74%	
	Santa Clara County		85%	
	Five counties	Ages 12–19	78%	
	San Francisco County		82%	
	San Mateo County		72%	
	Santa Clara County		79%	
Healthy Families	Statewide	Ages 7–11	85%	l
	Seven counties		85%	j
	San Francisco County		93%	
	San Mateo County		85%	
	Santa Clara County		85%	
	Statewide	Ages 12–19	81%	l
	Seven counties		70%	j
	San Francisco County		92%	
	San Mateo County		74%	
	Santa Clara County		80%	
Medi-Cal	Six counties	Ages 7–11	80%	j
	Los Angeles County		81%	
	San Francisco County		84%	
	Santa Clara County		81%	
	Six counties	Ages 12–19	76%	
	Los Angeles County		75%	
	San Francisco County		81%	
	Santa Clara County		75%	

Note: HEDIS is short for the Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service. HEDIS data in this table are based on the measure "Children and Adolescents' Access to Primary Care Practitioners," and reflect the percentage of enrollees who had one or more visits with a managed care organization (MCO) primary care practitioner. The HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

[a]Data reported are for the most recent year available. (See data source notes.)

[b]Wave 1 Healthy Kids Enrollee Survey in Los Angeles County conducted by Mathematica Policy Research, Inc. (MPR) under sub-contract to the Urban Institute in 2005. Cited in L. Dubay and E. Howell. "Los Angeles Healthy Kids Improves Access to Care for Young Children: Early Results from the Healthy Kids Evaluation." The Urban Institute Health Policy Briefs, No. 18, July 2006.

Table A.1 *(continued)*

[c]Tabulations from 2003-2004 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent of the federal poverty level (FPL). Rates are not reported for populations for which the sample size was less than 50.

[d]Tabulations from 2006-2007 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent FPL. None of the children in the sample for this follow-up survey were under 4 years of age. Rates are not reported for populations for which the sample size was less than 50.

[e]Survey data reported in G. Melnick, J. Mann, L. Blair-Lewis, S. Maerki, L. Green, and N. Dhanani. "Evaluation of the Los Angeles CalKids Program: Full Report." Center for Health Financing, Policy and Management, University of Southern California, February 2002.

[f]Tabulations from 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states by MPR. Rates are not reported for populations for which the sample size was less than 50.

[g]MPR analysis of data from the 2005 California Health Interview Survey (AskCHIS and the CHIS public use file; http://www.chis.ucla.edu). Rates are not reported for populations for which the estimates were statistically unstable.

[h]Administrative data from the Health Plan of San Mateo (HPSM), for children enrolled in 2004. Cited in E. Howell, D. Hughes, B. Courtot, and L. Palmer. "Evaluation of the San Mateo County Children's Health Initiative: Third Annual Report." Submitted to San Mateo County Children's Health Initiative Coalition, September 2006.

[i]Administrative data from LA Care Health Plan claims/encounter and enrollment data. Cited in A. Sommers, E. Howell, and I. Hill. "Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data." Urban Institute, June 2007. These data are likely underestimates of actual utilization due to data source limitations.

[j]HEDIS 2006. Cited in C. Feifer, T.E. Arpawong, L.M. Nascimento, G.D. Stevens, and M. Cousineau. "Outcomes from Children's Health Initiatives of California." Submitted to First 5 California, The California Endowment. Center for Community Health Studies, University of Southern California, March 2007. Aggregate rates are weighted averages across CHIs. Only CHIs that reported $\geq$ 30 beneficiaries in their eligible population were included in the analysis. HEDIS data for the Medi-Cal and Healthy Families programs were independently audited; Healthy Kids program data did not require such audits.

[k]HEDIS 2007. HEDIS data provided to MPR by the California Kids program in Orange County. Data are from the Children's Hospital of Orange County, which enrolls about 85 percent of CaliforniaKids children in Orange County.

[l]HEDIS 2005. Cited in "Healthy Families Health Plan Quality Measurement for Services Provided in 2005 – Revised." Available at http://www.mrmib.ca.gov/MRMIB/HFP/HEDIS05.pdf. Rates are aggregate program scores based on member-level data submitted by each health plan. Only plans with $\geq$ 30 beneficiaries in their eligible population were included in this analysis.

Table A.2. Measures of Service Use for Low-Income Children in California: Well-Child Visits

Insurance Program	Location	Population	Estimate[a]	Data Source
Well-Child Visit in Past 6 Months, Survey Data				
Healthy Kids	Los Angeles County	Enrolled one year		
		Ages 1–5	69%	b
	Santa Clara County	Enrolled one year		
		Ages 3–6	55%	c
		Ages 12–18	34%	
		Enrolled four years		
		Ages 4–6	53%	d
		Ages 12–18	50%	
Healthy Families	Statewide	Latino		
		Ages 3–6	52%	e
		Ages 12–17	52%	f
		Ages 12–18	34%	e
	Los Angeles County	Latino		
		Ages 12–17	43%	f
Medi-Cal	Statewide	Latino		
		Ages 3–6	53%	e
		Ages 12–17	54%	f
		Ages 12–18	33%	e
	Los Angeles County	Latino		
		Ages 12–17	45%	f
Well-Child Visit in Past 12 Months, Survey Data				
Healthy Families	Statewide	Latino		
		Ages 3–6	83%	f
		Ages 12–17	79%	f
	Los Angeles County	Latino		
		Ages 12–17	68%	
Medi-Cal	Statewide	Latino		
		Ages 3–6	79%	f
		Ages 12–17	75%	f
	Los Angeles County	Latino		
		Ages 12–17	78%	
Well-Child Visit in Past 12 Months, HEDIS Data				
Healthy Kids	Three counties	Ages 3–6	57%	g
	Los Angeles County		53%	
	San Francisco County		70%	
	San Mateo County		70%	
	Santa Clara County		67%	
	Three counties	Ages 12–18	26%	
	Los Angeles County		18%	
	San Francisco County		36%	
	San Mateo County		44%	
	Santa Clara County		42%	

Table A.2 *(continued)*

Insurance Program	Location	Population	Estimate[a]	Data Source
CaliforniaKids	Orange County	Enrolled one year		h
		Ages 3–6	60%	
		Ages 12–18	38%	
Healthy Families	Five counties	Ages 3–6	79%	g
	San Francisco County		76%	
	San Mateo County		74%	
	Santa Clara County		69%	
	Five counties	Ages 12–18	52%	
	San Francisco County		59%	
	San Mateo County		41%	
	Santa Clara County		45%	
Medi-Cal	Six counties	Ages 3–6	80%	g
	Los Angeles County		73%	
	San Francisco County		70%	
	San Mateo County		67%	
	Santa Clara County		69%	
	Seven counties	Ages 12–18	41%	
	Los Angeles County		37%	
	San Francisco County		41%	
	San Mateo County		32%	
	Santa Clara County		35%	
Well-Child Visit in Past 12 Months, Administrative Data				
Healthy Kids	Los Angeles County	Enrolled one year		i
		Ages 0–1	59%	
		Age 1	53%	
		Ages 2–5	44%	
		Ages 6–18	21%	
	San Mateo County	First year of enrollment		
		Ages 0–18	40%	j
Healthy Families	San Mateo County	First year of enrollment		
		Ages 0–18	55%	j
Medi-Cal	San Mateo County	First year of enrollment		
		Ages 0–18	40%	j

Note: HEDIS is short for the Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service. The HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

[a]Data reported are for the most recent year available. (See data source notes.)

[b]Healthy Kids Wave 2 Enrollee Survey in Los Angeles County conducted by Mathematica Policy Research, Inc. (MPR) under sub-contract to the Urban Institute in 2006-2007. Cited in E. Howell, L. Dubay, and L. Palmer. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status." The Urban Institute, July 2007.

Table A.2 *(continued)*

[c]Tabulations from 2003-2004 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent of the federal poverty level (FPL). Rates are not reported for populations for which the sample size was less than 50.

[d]Tabulations from 2006-2007 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent FPL. None of the children in the sample for this follow-up survey were under 4 years of age. Rates are not reported for populations for which the sample size was less than 50.

[e]Tabulations from 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states by MPR.

[f]MPR analysis of data from the 2005 California Health Interview Survey (AskCHIS; http://www.chis.ucla.edu). Rates not reported for populations for which the sample size was too small to yield reliable estimates.

[g]HEDIS 2006. Cited in C. Feifer, T.E. Arpawong, L.M. Nascimento, G.D. Stevens, and M. Cousineau. "Outcomes from Children's Health Initiatives of California." Submitted to First 5 California, The California Endowment. Center for Community Health Studies, University of Southern California, March 2007. Aggregate rates are weighted averages across CHIs. Only CHIs that reported $\geq$ 30 beneficiaries in their eligible population were included in the analysis. Rates reported were gathered using hybrid methodology, except in San Francisco County, which used administrative methodology. HEDIS data for the Medi-Cal and Healthy Families programs were independently audited; Healthy Kids program data did not require such audits.

[h]HEDIS 2007. HEDIS data provided to MPR by the CaliforniaKids program in Orange County. Data are from the Children's Hospital of Orange County, which enrolls about 85 percent of CaliforniaKids children in Orange County.

[i]Administrative data from LA Care Health Plan claims/encounter and enrollment data. Cited in Sommers, A., Howell, E., and Hill, I. "Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data." Urban Institute, June 2007. These data are likely underestimates of actual utilization due to data source limitations.

[j]Administrative data from the Health Plan of San Mateo (HPSM), for children enrolled in 2004. Cited in Howell, E., Hughes, D., Courtot, B., and Palmer, L. "Evaluation of the San Mateo County Children's Health Initiative: Third Annual Report." Submitted to San Mateo County Children's Health Initiative Coalition, September 2006.

CHI = Children's Health Initiative.

Table A.3. Measures of Service Use for Low-Income Children in California: Any Dental Visit

Insurance Program	Location	Population	Estimate[a]	Data Source
Any Dental Visit in Past 6 Months, Survey Data				
Healthy Kids	Los Angeles County	Enrolled one year		
		Ages 1–5	49%	b
	Santa Clara County	Enrolled one year		
		Ages 4–6	71%	c
		Ages 7–10	69%	
		Ages 11–14	63%	
		Ages 15–18	57%	
	Santa Clara County	Enrolled four years		
		Ages 4–6	65%	d
		Ages 7–10	71%	
		Ages 11–14	78%	
		Ages 15–18	66%	
Healthy Families	Statewide	Latino		
		Ages 2–4	22%	e
		Ages 4–6	53%	
		Ages 7–10	65%	
		Age 11	72%	
		Latino		
		Ages 4–6	66%	f
		Ages 7–10	72%	
		Ages 11–14	59%	
		Ages 15–18	51%	
	Los Angeles County	Statewide		
		Ages 7–10	67%	e
Medi-Cal	Statewide	Latino		
		Ages 2–3	34%	e
		Ages 2–4	44%	
		Ages 4–6	63%	
		Ages 7–10	59%	
		Age 11	51%	
	Statewide	Latino		
		Ages 4–6	65%	f
		Ages 7–10	71%	
		Ages 11–14	62%	
		Ages 15–18	48%	
	Los Angeles County	Latino		
		Ages 2–4	53%	e
		Ages 4–6	59%	
		Ages 7–10	53%	
		Age 11	46%	
Any Dental Visit in Past 12 Months, Survey Data				
Healthy Families	Statewide	Latino		
		Ages 2–4	49%	e
		Ages 4–6	81%	
		Ages 7–10	88%	
		Age 11	85%	

Table A.3 *(continued)*

Insurance Program	Location	Population	Estimate[a]	Data Source
	Los Angeles County	Latino		
		Ages 4–6	89%	
		Ages 7–10	90%	
Medi-Cal	Statewide	Latino		
		Ages 2–3	44%	e
		Ages 2–4	56%	
		Ages 4–6	82%	
		Ages 7–10	89%	
		Age 11	72%	
	Los Angeles County	Latino		
		Ages 2–4	65%	
		Ages 4–6	79%	
		Ages 7–10	87%	
		Age 11	64%	
CaliforniaKids	Los Angeles County	First year of enrollment		
		Ages 2–18	44%	g
Any Dental Visit in Past 12 Months, HEDIS Data				
Healthy Kids	Four counties	Ages 2–3	50%	h
	San Francisco County		53%	
	Santa Clara County		36%	
	Five counties	Ages 4–6	72%	
	San Francisco County		86%	
	Santa Clara County		68%	
	Five counties	Ages 7–10	74%	h
	San Francisco County		86%	
	Santa Clara County		75%	
	Five counties	Ages 11–14	63%	h
	San Francisco County		71%	
	Santa Clara County		68%	
	Five counties	Ages 15–18	59%	h
	San Francisco County		54%	
	Santa Clara County		58%	
California Kids	Orange County	Ages 4–6	74%	i
		Ages 7–10	64%	i
		Ages 11–14	75%	i
		Ages 15–18	75%	i
Any Dental Visit in Past 12 Months, Administrative Data				
Healthy Kids	San Mateo County	First year of enrollment		
		Ages 0–18	56%	j

Note: HEDIS is short for the Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service. The HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

[a]Data reported are for the most recent year available. (See data source notes.)

Table A.3 *(continued)*

[b]Healthy Kids Wave 2 Enrollee Survey in Los Angeles County conducted by Mathematica Policy Research, Inc. (MPR) under sub-contract to the Urban Institute in 2006-2007. Cited in E. Howell, L. Dubay, and L. Palmer. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status." The Urban Institute, July 2007.

[c]Tabulations from 2003-2004 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent of the federal poverty level (FPL). Rates are not reported for populations for which the sample size was less than 50.

[d]Tabulations from 2006-2007 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent FPL. None of the children in the sample for this follow-up survey were under 4 years of age. Rates are not reported for populations for which the sample size was less than 50.

[e]MPR analysis of data from the 2005 California Health Interview Survey (AskCHIS and the CHIS public use file; http://www.chis.ucla.edu). Rates are not reported for populations for which the estimates were statistically unstable. Only children ages 2-11 years (and younger children with teeth) were asked the survey question about dental visits.

[f]Tabulations from 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states by MPR. Rates are not reported for populations for which the sample size was less than 50.

[g]Survey data reported in G. Melnick, J. Mann, L. Blair-Lewis, S. Maerki, L. Green, and N. Dhanani. "Evaluation of the Los Angeles CalKids Program: Full Report." Center for Health Financing, Policy and Management, University of Southern California, February 2002.

[h]HEDIS 2006. Cited in C. Feifer, T.E. Arpawong, L.M. Nascimento, G.D. Stevens, and M. Cousineau. "Outcomes from Children's Health Initiatives of California." Submitted to First 5 California, The California Endowment. Center for Community Health Studies, University of Southern California, March 2007. Aggregate rates are weighted averages across CHIs. Only CHIs that reported $\geq$ 30 beneficiaries in their eligible population were included in the analysis. HEDIS data for the Medi-Cal and Healthy Families programs were independently audited; Healthy Kids program data did not require such audits.

[i]HEDIS 2007. Data provided to MPR by the dental plan (Safeguard) for the Orange County CaliforniaKids program. Data are from the Children's Hospital of Orange County, which enrolls about 85 percent of CaliforniaKids children in Orange County. The denominator for these data is 8,491 for children ages 2-18, while enrollment in the CaliforniaKids program averaged 4,972 per month in 2006. Thus, the denominator is likely an overestimate of the number of CaliforniaKids enrollees.

[j]Administrative data from the Health Plan of San Mateo (HPSM), for children enrolled in 2004. Cited in E. Howell, D. Hughes, B. Courtot, and L. Palmer. "Evaluation of the San Mateo County Children's Health Initiative: Third Annual Report." Submitted to San Mateo County Children's Health Initiative Coalition, September 2006.

Table A.4. Measures of Service Use for Low-Income Children in California: Any Emergency Department Visit

Insurance Program	Location	Population	Estimate[a]	Data Source
Any ED Visit in Past 6 Months, Survey Data				
Healthy Kids	Los Angeles County	Enrolled one year		
		Ages 1–5	17%	b
	Santa Clara County	Enrolled one year		
		Ages 1–5	24%	c
		Ages 6–18	15%	
		Ages 1–18	17%	
	Santa Clara County	Enrolled four years		
		Ages 6–18	12%	d
		Ages 4–18	13%	
CaliforniaKids	Los Angeles County	Ages 2–18	3%	e
Healthy Families	Statewide	Latino		
		Ages 1–5	20%	f
		Ages 6–18	13%	
Medi-Cal	Statewide	Latino		
		Ages 1–5	20%	f
		Ages 6–18	13%	
Any ED Visit in Past 12 Months, Survey Data				
Healthy Families	Statewide	Latino		
		Ages 0–5	28%	g
		Ages 6–18	14%	
Medi-Cal	Statewide	Latino		
		Ages 0–5	22%	g
		Ages 6–18	15%	
	Los Angeles County	Latino		
		Ages 0–5	22%	
		Ages 6–18	13%	
Any ED Visit in Past 12 Months, Administrative Data				
Healthy Kids	Seven counties	Ages 0–5	16%	h
	Los Angeles County		11%	
	San Francisco County		14%	
	Santa Clara County		12%	
	Seven counties	Ages 6–18	9%	
	Los Angeles County		6%	
	San Francisco County		6%	
	Santa Clara County		6%	
	San Mateo County	First year of enrollment		
		Ages 0–18	13%	i
	Los Angeles County	First year of enrollment		
		Under 1	21%	j
		Age 1	12%	
		Ages 2–5	9%	
		Ages 6–18	6%	

Table A.4 *(continued)*

Insurance Program	Location	Population	Estimate[a]	Data Source
Healthy Families	Six counties	Ages 0–5	27%	h
	Los Angeles County		24%	
	San Francisco County		15%	
	Santa Clara County		15%	
	Six counties	Ages 6–18	18%	
	Los Angeles County		12%	
	San Francisco County		4%	
	Santa Clara County		7%	
	San Mateo County	First year of enrollment Ages 0–18	16%	i
Medi-Cal	Six Counties	Ages 0–5	38%	h
	Los Angeles County		33%	
	San Francisco County		26%	
	Santa Clara County		24%	
	Six Counties	Ages 6–18	25%	
	Los Angeles County		18%	
	San Francisco County		12%	
	Santa Clara County		13%	
	San Mateo County	First year of enrollment Ages 0–18	32%	i
Any ED Visit in Past 12 Months, HEDIS Data				
CaliforniaKids	Statewide	Ages 2–9	13%	k
		Ages 10–19	13%	

Note: HEDIS is short for the Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service. The HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

[a]Data reported are for the most recent year available. (See data source notes.)

[b]Healthy Kids Wave 2 Enrollee Survey in Los Angeles County conducted by Mathematica Policy Research, Inc. (MPR) under sub-contract to the Urban Institute in 2006-2007. Cited in E. Howell, L. Dubay, and L. Palmer. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status." The Urban Institute, July 2007.

[c]Tabulations from 2003-2004 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent of the federal poverty level (FPL). Rates are not reported for populations for which the sample size was less than 50.

[d]Tabulations from 2006-2007 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent FPL. None of the children in the sample for this follow-up survey were under 4 years of age. Rates are not reported for populations for which the sample size was less than 50.

[e]Survey data reported in G. Melnick, J. Mann, L. Blair-Lewis, S. Maerki, L. Green, and N. Dhanani. "Evaluation of the Los Angeles CalKids Program: Full Report." Center for Health Financing, Policy and Management, University of Southern California, February 2002.

Table A.4 *(continued)*

[f]Tabulations from 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states by MPR.

[g]MPR analysis of data from the 2005 California Health Interview Survey (AskCHIS; http://www.chis.ucla.edu). Rates are not reported for populations for which the estimates were statistically unstable.

[h]Administrative data from health plans on the percent of children with at least one ED visit in 2005. Cited in C. Feifer, T.E. Arpawong, L.M. Nascimento, G.D. Stevens, and M. Cousineau. "Outcomes from Children's Health Initiatives of California." Submitted to First 5 California, The California Endowment. Center for Community Health Studies, University of Southern California, March 2007. Aggregate rates are weighted averages across CHIs. Only CHIs that reported $\geq$ 30 beneficiaries in their eligible population were included in the analysis.

[i]Administrative data from the Health Plan of San Mateo (HPSM), for children enrolled in 2004. Cited in E. Howell, D. Hughes, B. Courtot, and L. Palmer. "Evaluation of the San Mateo County Children's Health Initiative: Third Annual Report." Submitted to San Mateo County Children's Health Initiative Coalition, September 2006.

[j]Administrative data from LA Care Health Plan claims/encounter and enrollment data. Cited in A. Sommers, E. Howell, and I. Hill. "Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data." Urban Institute, June 2007. These data are likely underestimates of actual utilization due to data source limitations.

[k]HEDIS 2007. MPR calculation of HEDIS data provided by the CaliforniaKids program in Orange County. Data are from the Children's Hospital of Orange County, which enrolls about 85 percent of CaliforniaKids children in Orange County. MPR calculated these rates assuming members in the denominator were enrolled in the program for a full year. As such, these rates may be upper bound estimates of members' actual ED use.

ED = emergency department.

Table A.5. Measures of Service Use for Low-Income Children in California: Any Hospitalization

Insurance Program	Location	Population	Estimate[a]	Data Source
Stayed in Hospital at Least Overnight in Past 6 Months, Survey Data				
Healthy Kids	Los Angeles County	Enrolled one year		
		Ages 1–5	3%	b
	Santa Clara County	Enrolled one year		
		Ages 1–5	2%	c
		Ages 6–18	2%	
Healthy Families	Statewide	Latino		
		Ages 1–5	5%	d
		Ages 6–18	1%	
Medi-Cal	Statewide	Latino		
		Ages 1–5	5%	d
		Ages 6–18	2%	
Stayed in Hospital at Least Overnight in Past 12 Months, Survey Data				
Medi-Cal	Statewide	Latino		
		Ages 0–18	7%	e
		Ages 0–5	9%	
		Ages 1–5	6%	
		Ages 6–18	5%	
	Los Angeles County	Latino		
		Ages 0–18	9%	
		Ages 0–5	14%	
		Ages 6–18	7%	
Stayed in Hospital at Least Overnight in Past 12 Months, Administrative Data				
Healthy Kids	Los Angeles County	Enrolled one year		
		Ages 0–1	1%	f
		Ages 2–5	1%	
		Ages 6–18	1%	
	San Francisco County	Ages 0–24	2%	g
CaliforniaKids	Orange County	Ages 2–18	<1%	h

Note: HEDIS is short for the Healthcare Effectiveness Data and Information Set, a commonly-used tool developed to measure health plan performance across key dimensions of health care and service. The HEDIS data for the Healthy Kids and CaliforniaKids programs have not been audited for accuracy or completeness, a step that is normally required for validating the HEDIS tool.

[a]Data reported are for the most recent year available. (See data source notes.)

[b]Healthy Kids Wave 2 Enrollee Survey in Los Angeles County conducted by Mathematica Policy Research, Inc. (MPR) under sub-contract to the Urban Institute in 2006-2007. Cited in E. Howell, L. Dubay, and L. Palmer. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status." The Urban Institute, July 2007.

[c]Tabulations from 2003-2004 Survey of Healthy Kids Enrollees in Santa Clara County by MPR. Estimates only include children with household incomes at or below 250 percent of the federal poverty level (FPL). Rates are not reported for populations for which the sample size was less than 50.

Table A.5 *(continued)*

[d]Tabulations from 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states by MPR.

[e]MPR analysis of data from the 2001 California Health Interview Survey (AskCHIS; http://www.chis.ucla.edu). Rates are not reported for populations for which the estimates were statistically unstable.

[f]Administrative data from LA Care Health Plan claims/encounter and enrollment data. Cited in A. Sommers, E. Howell, and I. Hill. "Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data." Urban Institute, June 2007. These data are likely underestimates of actual utilization due to data source limitations.

[g]Administrative data provided to MPR by the San Francisco Healthy Kids program.

[h]Administrative data provided to MPR by the CaliforniaKids program in Orange County. Data are from the Children's Hospital of Orange County, which enrolls about 85 percent of CaliforniaKids children in Orange County. The data were reported as 8 hospitalizations per 5,000 members in a 20 month period. Some CaliforniaKids enrollees may have been excluded from this calculation. Thus, it is a lower bound estimate of actual hospital use.

APPENDIX B

SUPPORTING TABLES ON THE SIX LOCAL PROGRAMS EXAMINED FOR THIS STUDY

Table B.1. Characteristics of the CaliforniaKids Program in Marin County

Program Funding	
Funding mechanism	The program operates through contributions to an independent nonprofit organization, the CaliforniaKids Health Care Foundation. Key funders include the Marin Community Foundation and Marin First 5 Children's and Families Commission.[a] Blue Cross of California donates administrative services. Coordinates with Medi-Cal for inpatient services.
Program Eligibility	
General eligibility	To participate in CaliforniaKids, a child must be ages 2–18 and a resident of Marin County.
Family income limits	Children with family incomes of up to 250 percent of FPL.
Immigration status	Undocumented children (who meet other eligibility requirements)
Eligibility if covered by other health insurance	Children who are not eligible for full scope/no share of cost Medi-Cal, Healthy Families, or other state assistance programs for health care. May be enrolled in CCS for specialty care. May have other private insurance with a high deductible ($2,000 or more) and still be eligible for CaliforniaKids. May be enrolled in limited scope Medi-Cal.
Health Plan Benefits	
Covered benefits	Outpatient coverage only. Children requiring inpatient care are referred to Medi-Cal. Outpatient services covered include: office visits; follow-up treatments; specialist/consultants; diagnostic studies and treatments; outpatient laboratory services; injectable medications (administered in doctor's office); routine physicals and examinations (when ordered by physician); emergency care; vision and hearing examinations; lenses/frames; allergy testing and treatment; immunizations; health education; same-day outpatient surgery; diagnostic, laboratory and radiology services; preventive dental services; family assistance program; outpatient mental health.
Cost-Sharing	
Premiums	No premiums.
Out-of-pocket costs	Co-payments of $5–$10 for doctor's visits and prescriptions; no co-payment for preventive or restorative dental care (with the exception of a $5 co-pay for baby root canal); $50 for ED visits depending on the service.

Table B.1 *(continued)*

Network Design	
Who provides care	Provider networks of Blue Cross of California. Blue Cross has 3 provider groups: (1) CHOC Health Alliance (a nonprofit associated with Children's Hospital, has 5 community clinics), (2) Gateway, and (3) Regal Medical Group. Blue Cross contracts with SafeGuard for dental and vision services, and the Holman Group for mental health services.
Where care is delivered	At the site of providers who are in the Blue Cross network. Care is delivered at community clinics only. (Marin Community Clinic is the primary site of CaliforniaKids medical care in Marin. County Dental Clinic in San Rafael is the primary site of dental care.)
Care coordination and referral relationships	With Medi-Cal: coordinates with emergency Medi-Cal to pay for inpatient services. With CCS: child with a CCS-eligible condition receives treatment for the CCS condition from a CCS provider and remains enrolled in CaliforniaKids for basic outpatient services.
Provider Payments	
Provider payment structure	Capitated payments from HMOs.

Sources: CaliforniaKids Healthcare Foundation. "About CaliforniaKids and Summary of Benefits." [http://www.californiakids.org/aboutframe.html]. Accessed September 24, 2007.

CaliforniaKids Healthcare Foundation. "Our History, Our Experience, and Our Future." December 2006. [http://www.californiakids.org/history12-06.pdf]. Accessed September 24, 2007.

Institute for Health Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/WebsiteTableDocument_040607.pdf]. Accessed September 24, 2007.

Mannanal, Jolly. "Directory of Local Efforts to Expand Healthcare Access for California's Uninsured." Insure the Uninsured Project, January 2007. Available at [http://www.itup.org/Reports/Solutions/Local%20Efforts%20Report%202006.pdf]. Accessed September 24, 2007.

National Health Foundation. "CaliforniaKids." 2006. [http://www.champ-net.org/training/manual/ch6.pdf]. Accessed April 1, 2007.

Interviews with the CaliforniaKids executive director and staff in Marin County.

Table B.1 *(continued)*

[a]The Marin Community Foundation pays for program for children ages 6–18, excluding an additional dental option. First 5 pays for children ages 0–5. Marin County pays for additional dental coverage for children ages 6–18.

CCS = California Children's Services; CHOC = Children's Hospital of Orange County; ED = emergency department; FPL = federal poverty level; HMO = Health Maintenance Organization.

Table B.2. Characteristics of the CaliforniaKids Program in Orange County

Program Funding	
Funding mechanism	The program operates through contributions to an independent nonprofit organization, the CaliforniaKids Health Care Foundation. Key funders includes the California HealthCare Foundation, Hoag Memorial Hospital, St. Joseph Health System, and St. Joseph Hospital. Coordinates with Medi-Cal for inpatient services.
Program Eligibility	
General eligibility	To participate in CaliforniaKids, a child must be between ages 2 and 18 and a resident of Orange County.
Family income limits	Children with family incomes of up to 250 percent of FPL.
Immigration status	Undocumented children (who meet other eligibility requirements).
Eligibility if covered by other health insurance	Children who are not eligible for full-scope/no share of cost Medi-Cal, Healthy Families, or other state assistance programs for health care. May be enrolled in CCS for specialty care. May have other private insurance with a high deductible ($2,000 or more) and still be eligible for CaliforniaKids. May be enrolled in limited scope Medi-Cal (enrollment is facilitated by CaliforniaKids program).
Health Plan Benefits	
Covered benefits	Outpatient coverage only. Children requiring inpatient care are referred to Medi-Cal. Outpatient services covered include: office visits; diagnostics studies and treatments; lab services; preventive care; emergency care for true emergencies; prescriptions; eye exams; frames/lenses; dental services; family assistance program; access to 24-hour nurse services.
Cost-Sharing	
Premiums	Monthly premium of $15 per child with no income adjustments, $45 per family per month maximum.
Out-of-pocket costs	Co-payments of $5 for PCP visits; $25 for specialist visits; $3–$12 for dental visits; $50 for ED visits depending on the service; $5–$15 for prescriptions.

Table B.2 *(continued)*

Network Design	
Who provides care	Provider networks of Blue Cross of California. Blue Cross has 3 provider groups: (1) CHOC Health Alliance (a nonprofit associated with Children's Hospital, has 5 community clinics), (2) Gateway, and (3) Regal Medical Group. Blue Cross contracts with SafeGuard for dental and vision services, and the Holman Group for mental health services.
Where care is delivered	At the site of providers who are in the Blue Cross network.
Care coordination and referral relationships	With Medi-Cal: Coordinates with emergency Medi-Cal to pay for inpatient services. With CCS: Child with a CCS-eligible condition receives treatment for the CCS condition from a CCS provider and remains enrolled in CaliforniaKids for basic outpatient services.
Provider Payments	
Provider payment structure	Capitated payments from HMOs.

Sources: CaliforniaKids Healthcare Foundation. "About CaliforniaKids and Summary of Benefits." [http://www.californiakids.org/aboutframe.html]. Accessed September 24, 2007.

CaliforniaKids Healthcare Foundation. "Our History, Our Experience, and Our Future." December 2006. [http://www.californiakids.org/history12-06.pdf]. Accessed September 24, 2007.

Institute for Healthy Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/ WebsiteTableDocument_011107_rev2.pdf]. Accessed April 1, 2007.

Mannanal, Jolly. "Directory of Local Efforts to Expand Healthcare Access for California's Uninsured." Insure the Uninsured Project, January 2007. Available at [http://www.itup.org/Reports/Solutions/Local%20Efforts%20Report%202006.pdf]. Accessed September 24, 2007.

National Health Foundation. "CaliforniaKids." 2006. [http://www.champ-net.org/training/manual/ch6.pdf]. Accessed April 1, 2007.

Interviews with the CaliforniaKids executive director and staff in Orange County.

CCS = California Children's Services; ED = emergency department; FPL = federal poverty level; HMO = Health Maintenance Organization.

Table B.3. Characteristics of the Healthy Kids Program in San Francisco County[a]

Program Funding	
Funding mechanism	Funding for the program comes from general revenue funds from the city and county of San Francisco, First 5 San Francisco County, and First 5 California.
Program Eligibility	
General eligibility	To participate in Healthy Kids, a child must be under 21 years of age and a resident of San Francisco County.
Family income limits	Children with family incomes of under 300 percent of FPL.
Immigration status	Undocumented and documented children (who meet other eligibility requirements).
Eligibility if covered by other health insurance	Children who are not eligible for full scope/no share of cost Medi-Cal or Healthy Families. Children must be uninsured and not have been covered by private insurance within the last 90 days (unless the employer dropped coverage). May be enrolled in limited scope Medi-Cal. May be enrolled in CCS for specialty care.
Health Plan Benefits	
Covered benefits	Comprehensive medical, dental, vision, and mental health benefits. Benefits mirror Healthy Families.
Cost-Sharing	
Premiums	Varies by family income level. Monthly premiums range from $4–$9 per child ($4 if < 200 percent FPL; $9 if 201–300 percent FPL). Premiums are paid annually by families ($48–$108/year). Annual premium is collected at enrollment and each year at child's anniversary date. Premium assistance is available based on family income or special circumstances.

Table B.3 *(continued)*

Out-of-pocket costs	Co-payments of $5 for the following services: outpatient medical visits; inpatient and outpatient medical and surgical services; outpatient mental health services; outpatient alcohol or drug abuse treatment; home visits; physical, occupational, and speech therapy; and biofeedback. Orthotics are not a covered benefit, unless deemed necessary for a diabetic child. Co-payment of $15 for emergency services. Co-payments are limited to $250 per family per year. No co-payments for preventive visits. No co-payments for children under the age of 24 months for well-baby care and office visits. No co-payments for documented Alaskan Natives or Native Americans. No deductibles and no lifetime financial benefit maximums for any of the covered benefits.
Network Design	
Who provides care	Providers within the San Francisco Health Plan network, with the sole exception that Healthy Kids cannot use Kaiser Permanente providers (these are restricted to SFHP's Medi-Cal enrollees). Mental health benefits are provided by the San Francisco Mental Health Plan (SFMHP). SFHP contracts with Delta Dental for dental services, and the Vision Service Plan for vision services.
Where care is delivered	At the site of providers who are in the network. Includes private physicians, community and county clinics, public and private hospitals, and pharmacies as well as dental, vision, and mental health service providers.
Care coordination and referral relationships	With CCS: Child with a CCS-eligible condition receives treatment for the CCS condition from a CCS provider and remains enrolled Healthy Kids for general care. In general, if child was in the middle of treatment with a non-plan provider when first enrolled in Healthy Kids, child may be able to complete treatment with that provider if the treatment is for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness, or if the child is up to 36 months of age and has received authorization from the provider for surgery or another procedure as part of a documented course of treatment. Non-contracted provider must agree to a rate of payment and abide by San Francisco Health Plan's policies and procedures.

Table B.3 *(continued)*

Provider Payments	
Provider payment structure	Individual providers are paid as follows: • Contracted medical groups and contracted hospitals are paid on a capitation basis. • Some other providers are paid on a fee-for-service basis. • Hospitals may enter into incentive arrangements with affiliated medical groups, such that the hospital and medical group share in the cost of services and the medical group may receive a bonus if the cost of services is below a fixed amount.

Sources: Institute for Healthy Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/ WebsiteTableDocument_011107_rev2.pdf]. Accessed April 1, 2007.

L.A. Care Health Plan. "Healthy Kids Program Member Handbook 2005-2006, Combined Evidence of Coverage and Disclosure Form, July 1, 2005 to June 30, 2006." [http://www.lacare.org/opencms/export/download/members/08_LA0012_0705_HK_EOC_en.pdf]. Accessed September 28, 2007.

Interviews with San Francisco Health Plan staff in San Francisco County.

[a]San Francisco's Healthy Kids and Young Adults program also provides coverage to young adults ages 21–24. Program eligibility, benefits, and cost sharing differ for this age group. This table focuses on how the program operates for children under age 21.

CCS = California Children's Services; FPL = federal poverty level.

Table B.4. Characteristics of the Healthy Kids Program in Santa Clara

Program Funding	
Funding mechanism	Funding for the program comes from city and county funds (tobacco settlement money from Santa Clara County and city of San José), First 5 Santa Clara County, the David and Lucile Packard Foundation, The California Endowment, The Health Trust, Blue Shield of California Foundation, other foundations, corporations and individuals, and the Santa Clara Family Health Plan.
Program Eligibility	
General eligibility	To participate in Healthy Kids, a child must be under 19 years of age and a resident of Santa Clara County.
Family income limits	Children with family incomes of up to 300 percent of FPL.
Immigration status	Undocumented and documented children (who meet other eligibility requirements).
Eligibility if covered by other health insurance	Children who are not eligible for full scope/no share of cost Medi-Cal or Healthy Families. May be enrolled in limited scope Medi-Cal. Not covered by employer-sponsored health insurance. May be enrolled in CCS for specialty care.
Health Plan Benefits	
Covered benefits	Comprehensive medical, dental, vision, prescription, and mental health benefits. Benefits mirror Healthy Families.
Cost-Sharing	
Premiums	Varies by family income level. Monthly premiums range from $4-$12 per child ($4 if <150 percent FPL; $6 if 151–250 percent FPL; $12 if 251–300 percent FPL); $36 maximum per family per month. A premium assistance fund is available for families who cannot afford the monthly premium amount.

Table B.4 *(continued)*

Out-of-pocket costs	Co-payments of $5 for the following services: outpatient professional services and consultations; outpatient emergency health services and care; prescription drugs; oral surgery, prosthetics; outpatient mental health services; physical, occupational, and speech therapy; inpatient/outpatient chemical dependency services; and abuse treatment. No co-payment for the following services: inpatient medical services; preventive medical services; diagnostic, periodontic, and endodontic dental services; inpatient mental health services, diagnostic x-ray and laboratory services; inpatient health facilities; contraceptive drugs and devices; and health education. Co-payments are limited to $250 per family per year (excluding vision and dental services).
Network Design	
Who provides care	County and community clinics, individual providers; Packard Children's Hospital; two IPAs (Premier Care and Physician's Medical Group of San José); and two multi-specialty medical groups.
Where care is delivered	At the site of providers who are in the network. Includes private physicians, community and county clinics, public and private hospitals, and pharmacies as well as dental, vision, and mental health service providers.
Care coordination and referral relationships	With CCS: Child with a CCS-eligible condition receives treatment for the CCS condition from a CCS provider and remains enrolled Healthy Kids for general care. In general, if child was in the middle of treatment with a non-plan provider when first enrolled in Healthy Kids, child may be able to complete treatment with that provider for certain conditions (acute, serious chronic, imminent surgery, newborn care, pregnancy, terminal illness).
Provider Payments	
Provider payment structure	Providers are paid as follows: • Valley Health Plan network (which includes the County Health and Hospital System and private non-profit clinics) is capitated for professional and facility services. • Primary Care Physicians usually are paid on a capitated basis; preventive services are paid fee-for-service. • Provider groups who are under direct contracts are paid on a capitated basis. In turn, these provider groups pay individual providers on a capitated or fee-for-service basis. • Specialists usually are paid on a fee-for-service basis. • Dentists are paid on a fee-for-service basis. • Hospitals are typically paid on a pre diem basis. Only one hospital , the Santa Clara Valley Medical Center, is paid on a capitated basis.

Table B.4 *(continued)*

Sources: Institute for Healthy Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/ WebsiteTableDocument_011107_rev2.pdf]. Accessed April 1, 2007.

Santa Clara Family Health Plan. "Combined Evidence of Coverage & Disclosure." Benefit Year July 1, 2005 to June 30, 2006. [http://www.scfhp.com/bp/All/Docs/ EOC/HKEOCENG.pdf]. Accessed July 3, 2007.

Interviews with Santa Clara Family Health Foundation staff in Santa Clara County.

CCS = California Children's Services; FPL = federal poverty level.

Table B.5. Characteristics of the Healthy Kids Program in Solano County

Program Funding	
Funding mechanism	Funding for the program comes from Solano County (tobacco funds and county matching funds from general revenue), First 5 Solano, First 5 California, United Way, The California Endowment, Blue Shield Foundation, other foundations, local businesses, service clubs, and individuals. Program funding secured through the Solano Coalition for Better Health.
Program Eligibility	
General eligibility	To participate in Healthy Kids, a child must be under 19 years of age and a resident of Solano County.
Family income limits	Children with family incomes of up to 300 percent of FPL.
Immigration status	Undocumented and documented children (who meet other eligibility requirements)
Eligibility if covered by other health insurance	Children who are not eligible for full scope/no share of cost Medi-Cal or Healthy Families. Children must be uninsured and not have been covered by private insurance for the previous 3 months (unless the employer dropped coverage). May be enrolled in limited scope Medi-Cal. May be enrolled in CCS for specialty care.
Health Plan Benefits	
Covered benefits	Comprehensive medical, dental, vision, prescriptions, and mental health benefits. Benefits mirror Healthy Families.
Cost-Sharing	
Premiums	Varies by family income level. Monthly premiums range from $7 to $15 per child ($7 if <250 percent FPL; $15 if 250–300 percent FPL); $45 maximum per family per month. Program can subsidize premiums, if needed.

Table B.5 *(continued)*

Out-of-pocket costs	Co-payments of $5 for the following outpatient services: non-preventive medical visits; periodontal and endodontic dental services; oral surgery; allergy testing/treatment; urgent care services; physical, occupational, and speech therapy; prescription drugs; mental health services (20 visits/year; no limit for severe conditions); substance abuse services (20 visits/year); acupuncture and chiropractic treatment (20 visits/year); biofeedback; routine vision examinations; and glasses. Co-pay of $5 for most types of oral surgery and for removable oral prosthetics. No co-payment for the following services: inpatient/outpatient hospital services; preventive medical services (physical exams, well baby/child care, hearing/vision tests, immunizations); preventive and diagnostic dental visits; ambulance services; blood and blood products; family planning services; diagnostic x-ray/lab procedures; durable medical equipment (orthotics and prosthetics); home health care; hospice; inpatient physical/occupational/speech therapy; pregnancy and maternity care; inpatient mental health services (30 days/year); inpatient substance abuse services (30 days/year); hearing aids (every 36 months). Co-payments are limited to $250 per family per year.
Network Design	
Who provides care	Provider networks of the Partnership HealthPlan of California (PHC). PHC contracts with Delta Dental for coverage of dental services, United Behavioral Health for mental health services, and Vision Service Plan for vision services.
Where care is delivered	At the site of providers who are in the network. Includes private physicians, community and county clinics, public and private hospitals, and pharmacies as well as dental, vision, and mental health service providers.
Care coordination and referral relationships	With CCS: Child with a CCS-eligible condition receives treatment for the CCS condition from a CCS provider and remains enrolled Healthy Kids for general care. In general, if child was in the middle of treatment with a non-plan provider when first enrolled in Healthy Kids, child may be able to complete treatment with that provider for certain conditions (acute conditions, serious chronic conditions, pregnancy, terminal illness, a pending surgery/procedure). In addition, children ages 0-36 months may keep their existing providers for up to 12 months, whether in an active course of treatment or not.
Provider Payments	
Provider payment structure	Physicians/health care providers are paid on a fee-for-service basis. Some Ancillary services are capitated, including vision and lab. Dental services are also capitated. Hospitals and other health care facilities are paid on a per diem basis. Not all services are covered under the per diem rate.

Table B.5 *(continued)*

Sources: Institute for Health Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/WebsiteTableDocument_040607.pdf]. Accessed September 24, 2007.

Partnership HealthPlan of California. "Healthy Kids Health Plan Combined Evidence of Coverage and Disclosure Form." [http://www.partnershiphp.org/ Members/HK_EOC_EN.pdf]. Accessed October 30, 2007.

Solano Coalition for Better Health. "Current Initiatives and Programs." [http://www.solanocoalition.org/initiativesprograms/initiatives.asp]. Accessed October 30, 2007.

Interviews with Partnership HealthPlan of California staff in Solano County.

CCS = California Children's Services; FPL = federal poverty level; HMO = Health Maintenance Organization.

Table B.6. Characteristics of the Healthy Kids Program in Los Angeles County

Program Funding	
Funding mechanism	Funding for the program comes from a coalition of community groups, including LA Care, Blue Shield of California Foundation, The California Endowment, UniHealth, Parson's Foundation, California Community Foundation, Kaiser Permanente, First 5 California, the California Health Care Foundation, and QueensCare.
Program Eligibility	
General eligibility	To participate in Healthy Kids, a child must be under 19 years of age and a resident of Los Angeles County.
Family income limits	Children with family incomes of up to 300 percent of FPL.
Immigration status	Undocumented and documented children (who meet other eligibility requirements).
Eligibility if covered by other health insurance	Children who are not eligible for full scope/no share of cost Medi-Cal or Healthy Families. Children who are not eligible for job-based health insurance. May not be covered by any other publicly sponsored health insurance plan or independently purchased health coverage. May be enrolled in limited scope Medi-Cal. May be enrolled in CCS for specialty care.
Health Plan Benefits	
Covered benefits	Comprehensive medical, dental, vision, prescription, and mental health benefits. Benefits mirror Healthy Families with two exceptions: (1) dental (Healthy Kids has an increased capitation rate to compensate for safety net providers who co-located dental services in their clinic); and (2) mental health (Healthy Kids enrollees referred to PacifiCare Behavioral Health carve out for severe conditions, Healthy Families enrollees have to go through public system, LA County Mental Health, which involves greater barriers).
Cost-Sharing	
Premiums	Varies by family income level. Monthly premiums range from \$0–\$6 per child (\$0 if < 133 percent FPL; \$4 if 134–150 percent FPL; \$6 if 151–300 percent FPL); \$12 maximum per family per month. A premium assistance fund is available for families who cannot afford the monthly premium amount.

Table B.6 *(continued)*

Out-of-pocket costs	Co-payments of $5 for the following services: outpatient prescription drugs; outpatient mental health, alcohol, and drug abuse services; cancer clinical trial visits; diabetic care; emergency care; physical, occupational, and speech therapy in outpatient setting; pediatric asthma care; restorative dental services. No co-payment for the following services: preventive services; hospital inpatient services; inpatient mental health, alcohol, and drug abuse services; blood and blood products; cataract spectacles and lenses; most dental services; diagnostic x-ray and laboratory services; durable medical equipment; eye exams/supplies; family planning services; health education services; hearing aids/services; home health care; hospice; medical transportation; inpatient prescription drugs; contraceptive drugs and devices; prostheses; reconstructive surgery; transplants; vision services. Co-payments are limited to $250 per family per year (excluding vision and dental services).
Network Design	
Who provides care	Provider networks of the LA Care Health Plan. The PCPs are part of Participating Provider Groups (PPGs) which are part of larger medical groups that work with certain specialists, hospitals, and other health care providers. LA Care contracts with Safeguard for dental services, Vision Service Plan for vision services, and PacifiCare for mental health services for severe conditions.
Where care is delivered	At the site of providers who are in the PCP's PPG. Includes private physicians, community and county clinics, public and private hospitals, and pharmacies, as well as dental, vision, and mental health service providers.
Care coordination and referral relationships	With CCS: Child with a CCS-eligible condition receives treatment for the CCS condition from a CCS provider and remains enrolled Healthy Kids for general care. In general, if child was in the middle of treatment with a non-plan provider when first enrolled in Healthy Kids, child may be able to complete treatment with that provider for certain conditions (acute, serious chronic, imminent surgery, newborn care, pregnancy, terminal illness), if child's prior coverage did not allow receipt of care from an out-of-network provider or family did not have the option of remaining with the prior plan.

Table B.6 *(continued)*

Provider Payments	
Provider payment structure	Plan contracts with PPGs rather than directly with physicians. PPGs are typically paid on a capitated basis. PPGs are paid fee-for-service for some services (emergency department visits, outpatient surgery, and EPSDT services). Other payment structures exist with certain PPGs (including shared risk; per diem payments for primary care services and FFS payments for everything else; FFS payments only). Hospitals contract directly with LA Care rather than with PPGs. Hospitals are usually paid a per diem rate.

Sources: Institute for Health Policy Solutions. "Overview of Local Children's Coverage Expansions." [http://www.ihps-ca.org/localcovsol/_pdfs/WebsiteTableDocument_040607.pdf]. Accessed September 24, 2007.

L.A. Care Health Plan. "Healthy Kids Program Member Handbook 2005-2006, Combined Evidence of Coverage and Disclosure Form, July 1, 2005 to June 30, 2006." [http://www.lacare.org/opencms/export/download/members/08_LA0012_0705_HK_EOC_en.pdf]. Accessed September 28, 2007.

L.A. Care Health Plan. "L.A. Care's Healthy Kids Program." [http://www.lacare.org/opencms/opencms/en/members/programs/healthy_kids/index.html#diseasemanagementprogram]. Accessed September 28, 2007.

Interviews with LA Care staff in Los Angeles County.

CCS = California Children's Services; EPSDT = Early and Periodic Screening, Diagnosis and Treatment; FPL = federal poverty level; PPG = Preferred Provider Group.