

**Evaluation of the San Mateo County Children's Health Initiative:  
First Annual Report**

Embry Howell, Urban Institute  
Dana Hughes, University of California San Francisco  
Holly Stockdale, Urban Institute  
Martha Kovac, Mathematica Policy Research

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San Mateo County  
Children's Health Initiative Coalition  
225 37th Ave.  
San Mateo, CA 94403

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## EXECUTIVE SUMMARY

In January, 2003 partners in San Mateo County, California launched the Children's Health Initiative (CHI), a program designed to ensure that 100 percent of the County's children have access to comprehensive health insurance coverage. The partners—key public and private organizations in the county<sup>1</sup>--have assembled a diverse funding base for the initiative. In spite of an economic downturn in the county and across the state, over \$7 million from public and private sources was raised to fund the CHI for calendar year 2004.<sup>2</sup> The goal is to provide health insurance coverage to at least 14,600 uninsured children in the county through two strategies: (1) increasing the number of children enrolled in existing public health insurance programs, Healthy Families and Medi-Cal; and (2) establishing a new health insurance product, Healthy Kids, for children who are not entitled to other forms of public or employer-based insurance.

In order to accomplish this ambitious goal, the county partners have conducted “in reach” at existing health and social services sites where families of uninsured children come for services; held numerous outreach/enrollment events to advertise the availability of insurance and to sign children up; and used outreach partners throughout the county, including schools and Community Based Organizations, to identify and enroll uninsured children. They also designed the Healthy Kids insurance product to mirror the benefits of Healthy Families, and to be administered by the Health Plan of San Mateo, an existing health plan that provides services to Medi-Cal and some Healthy Families enrollees. The partners designed and implemented these features over the period mid-2001 to early 2003, with enrollment in Healthy Kids beginning in January 2003. Rapid implementation was facilitated by several factors, including previous positive working relationships among the partners and existing models in neighboring Santa Clara and San Francisco Counties.

The Urban Institute—along with consultant Dana Hughes of the University of California at San Francisco; Mathematica Policy Research; and the Aguirre Group—were chosen to evaluate the San Mateo County CHI. The evaluation, beginning in May 2003, spans five years, and includes multiple evaluation components and data sources. This first annual report includes data from a comprehensive site visit in October, 2003; aggregate data on demographic characteristics, health service use, and cost from the Health Plan of San Mateo; and aggregate data from the members of the Hospital Consortium on services and uncompensated care. Future evaluation reports will include data from these same sources, as well as information from two rounds of client surveys; a population-based survey sponsored by the First 5 San Mateo Commission; and focus groups of parents, providers, and employers. Highlights of findings from the first annual report are organized according to the evaluation research questions, as follows.

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<sup>1</sup> The key partners are: the county's Health Services and Human Services Agencies; the Health Plan of San Mateo; the First 5 San Mateo Commission; the Peninsula Community Foundation; the Hospital Consortium of San Mateo; and the San Mateo County Central Labor Council.

<sup>2</sup> The major funding sources, in order of size, are the county, the First 5 San Mateo County Commission (using Proposition 10 tobacco tax revenue), two local hospital districts, and private foundations.

*How did health insurance coverage change for children in San Mateo County?*

In its early months, the CHI achieved rapid enrollment growth in the Healthy Kids program. This growth is a reflection both of the pent up demand for children's health insurance by low income uninsured children in the county, as well as effective outreach to find and enroll them. By mid-2003, the CHI had enrolled 2,584 children into Healthy Kids. Rapid growth continued throughout the first year, and by January 2004, 4,893 children were enrolled in Healthy Kids (more than double the year one enrollment target). Enrollment in the Healthy Kids program far exceeded anticipated levels during this first year. We conclude that "in-reach" in clinics, as well as intensive school and community outreach, were very good approaches to enrolling the Healthy Kids target population. The successful outreach for Healthy Kids is a product of intensive and sustained collaboration among the CHI partners.

The case for rapid increased enrollment in Healthy Families and Medi-Cal is not so clear. The CHI seeks only to enroll children in Healthy Kids if they are ineligible for the other programs or for private insurance. While Healthy Families did grow during the first 6 months following CHI implementation, it had been growing equally rapidly during the year prior to implementation. Medi-Cal child enrollment actually fell slightly in the early months of the CHI. It is possible that—with cuts in state Healthy Families outreach—Healthy Families' growth might actually have been lower without the CHI. Also, we heard of some improvement in employment in the San Mateo County service sector in 2003; this, along with some programmatic changes related to Medi-Cal recertification, could be reasons for the Medi-Cal enrollment declines. For obvious reasons, it is important to make certain that uninsured children who are eligible for Medi-Cal or Healthy Families are enrolled in these programs, so we recommend that the "screen and enroll" process be monitored periodically to ensure that limited Healthy Kids dollars are reserved for children ineligible for other programs.

*Who is served by the San Mateo County CHI?*

Most Healthy Kids are from poor immigrant families. About 80% of Healthy Kids enrollees have Spanish as their primary language, the majority have incomes below 150% of the poverty level, and fully 92% are undocumented. Healthy Kids enrollees are primarily school aged children and adolescents, which mirrors the age profile for Healthy Families. In contrast, Medi-Cal enrollees are more often pre-school aged children.

*What services did Healthy Kids enrollees receive as part of the initiative? Did the CHI affect access to care for children who enrolled? Did the CHI affect where services were received?*

The purpose of enrollment in health insurance is to give children new access to health services. Using administrative data from the Health Plan of San Mateo for the first six months of the Healthy Kids program (continuous enrollees for the period mid-February 2003 to mid-August 2003), we found relatively low rates of service use, when compared to the other two public programs (Healthy Families and Medi-Cal) and to national benchmarks. For example, only 16% of the 532 Healthy Kids enrollees studied had a preventive care visit during their first six months on Healthy Kids. Rates of use of other ambulatory care were higher, and there may be miscoding

of visits and other data anomalies that bias these comparisons. For example, slightly over half of children in all three programs had at least one ambulatory care visit over six months.

Healthy Kids enrollees had relatively low use of the emergency room and hospital in their first six months on the program, a sign that when they are obtaining health care it is in appropriate locations. This also may be a sign that their health status is relatively good, when compared, for example, to Medi-Cal children.

It will be important to monitor use over time to determine whether these initial patterns are stable, or whether they reflect initially low use of services by a newly-insured group. It will also be important to further understand the relatively low proportion of children receiving preventive care, to determine whether it indicates a need for parental education about the importance of preventive care.

### ***Did the CHI affect the cost of care?***

Healthy Kids enrollees were the least expensive of the three public programs, followed by Healthy Families and then Medi-Cal child enrollees. Publicly insured children in San Mateo County appear to be much less expensive than the average child nationally. Until data are collected in the year three round of the client survey, it will not be apparent whether the cost of care is lowered with the CHI, or whether there has been a shift in the burden of paying for that care.

### ***Did the CHI enhance the delivery and stability of the community health care system?***

Very preliminary data for the early months of the CHI show some decline in hospital admissions and emergency room visits for uninsured children, and in uncompensated care at the San Mateo Medical Center. These preliminary statistics are potentially promising, but it is too soon to attribute a strong effect of the CHI on the finances of the medical center or other hospitals, since the CHI was very new during the period studied. Given declining federal and state dollars for local health services, the CHI may help to stabilize the financing of the San Mateo County health system for low income people, a pattern that will be monitored in future years of the evaluation.

### ***Has the CHI increased community-wide collaboration to address issues of the uninsured?***

Our process analysis found that San Mateo County has a high degree of cross-agency and cross-county collaboration. While this collaboration was a precursor to, and indeed led to, the CHI, it also appears to have been strengthened as a result of the CHI effort.

**Factors in Success.** The factors in the success of the first year of the San Mateo County CHI provide lessons for other jurisdictions that want to develop similar initiatives. In our interviews, we heard about three prominent factors that were key to the first year of successful implementation. First it was critical to have a core group of involved partners from diverse organizations—public and private—dedicated to common goals. We heard repeatedly of the commitment, passion, optimistic attitude, and gifts of in-kind time and resources from the San Mateo County CHI partners.

Second, it was important to learn from other similar projects, and translate their experience into local circumstances. San Mateo County particularly benefited from the examples of Santa Clara and San Francisco counties. These counties provide models for design and development that San Mateo County CHI partners closely observed as they proceeded with key decisions.

Finally, and perhaps most importantly, the San Mateo County CHI succeeded in developing a diverse funding base for the initiative, even in difficult financial times. This broad collaboration across sectors brought in private sources of financing. The CHI also successfully tapped some unique local funding sources (such as the hospital districts and tobacco tax financing) that may or may not be available in other places. Creating such a diverse funding base requires political skills and attention to the concerns and requirements of each funder.

**Future Challenges.** Based on our process analysis, we also identified some particular challenges on which the San Mateo County partners may want to focus attention as they enter the second year of the CHI. First, in order to improve the health status of low income children in the county, it may be necessary to adapt outreach and educational approaches. While “in-reach” has been successful and should be continued, the CHI may not be fully reaching children who are not yet seeking health care. Also, there does not seem to be a strong effort in place to follow up with the parents of children who are enrolled, in order to educate them about the importance of preventive care. Fortunately, there is a firm base upon which to build such outreach and education, although new partners may be useful.

Our site visit raised questions about the strength of the private provider network, in general, and the availability of dental services specifically. It is important that there be dentists and private physicians actively participating in CHI deliberations, in order to solicit help in CHI efforts. For example, private providers both could identify children in their practices who need health insurance coverage, as well as assure access by continuing to provide care to them once they are enrolled. Thus, further initiatives to involve private providers are critical to expanding access to care, especially for higher income families who may need health insurance coverage but be reluctant to enroll their children in Healthy Kids if their providers do not participate.

Another area for consideration is the complexity of the enrollment and funds transfer processes. Partners are already beginning to fine-tune these processes that were set up for expediency to begin rapid CHI implementation, and there are good reasons for continuing some apparently complex procedures that are working well. Still a thoughtful examination of them, perhaps in comparison to the way that similar processes are handled in neighboring counties, could lead to some efficiency.

Finally, in terms of challenges facing the CHI, external factors will have an important influence on how the CHI proceeds. It goes without saying that one looming issue for the CHI is the future of the Health Plan of San Mateo. In addition, the way that the state addresses its budget issues, both in financing Medi-Cal and Healthy Families, will provide major challenges to the CHI. The partners are fully aware of these issues and are working collectively to both monitor developments and to seek solutions.

## INTRODUCTION

In February 2003, San Mateo County launched its Children's Health Initiative (CHI), the goal of which is to assure that all children in the county have health insurance. To fill gaps in other public program coverage (i.e., for undocumented children and for children above 250% of poverty), the county created a new insurance product called "Healthy Kids." In addition to the creation of Healthy Kids, the CHI is designed to conduct outreach and enrollment for two other public insurance programs, Medi-Cal (Medicaid) and Healthy Families (State Child Health Insurance Program-SCHIP). This initiative is one of several similar initiatives being implemented in California counties, including in Santa Clara and San Francisco, among others.

In conjunction with the implementation of the CHI, the architects and major stakeholders decided to evaluate the initiative. The evaluation is being conducted under contract with the Urban Institute, consultant Dana Hughes of the University of California, San Francisco (UCSF), and sub-contractors Mathematica Policy Research and the Aguirre Group. The evaluation spans five years and has the following basic analytic components:

- *Process Analysis:* An analysis of the process of implementing the CHI.
- *Descriptive Program Analysis:* A description of program enrollees and how their characteristics change over time.
- *Provider Analysis:* An analysis of the effect of the new system on providers.
- *Health Insurance Coverage and Crowd-Out:* An analysis of improvements in health insurance coverage and crowd-out of private insurance.
- *Impact Analysis:* An analysis of the impact of the program on access, use, health status, satisfaction, and cost.

The specific research questions that the evaluation will address are shown in Table 1, along with the data sources that the evaluation team will analyze to address each question. The data sources include the following: annual site visits; focus groups with providers, parents, and employers; hospital consortium data on uncompensated care; health plan administrative data; First 5 population survey data; and a client survey which will occur in years one and three of the evaluation. The results from these analyses will be provided to the San Mateo County Children's

Health Initiative partners in brief quarterly reports, as well as annual reports in each year of the five-year evaluation contract.

As the evaluation proceeds over the five years, different data collection activities will occur during each year, as shown in Table 2, resulting in different types of information available for analysis each year. This first year evaluation report provides a process analysis based on information from the first site visit, a descriptive program analysis using aggregate data from the health plan and San Mateo Medical Center. Since only a subset of evaluation data sources are used in this first annual report, only a subset of the evaluation's research questions can be addressed this year, some of them only partially, including:

- Did health insurance coverage change for children in San Mateo County?
- Who was served by the San Mateo County CHI?
- What services did children receive as part of the initiative?
- Did the CHI affect where those services were received?
- Did the CHI affect the cost of care?
- Did the CHI affect access to care for children who enrolled?
- Did the CHI enhance the delivery and stability of the community health care system?
- Did the CHI increase community-wide collaboration to address issues of the uninsured?

## **SAN MATEO COUNTY**

In order to understand the implementation of the San Mateo CHI, it is important first to understand the context in which it is being implemented, both the demographic and economic characteristics of the county, as well as the health services system in which the initiative operates.

There were about 162,000 children residing in San Mateo County at the time of the 2000 census. This group of children is ethnically very diverse, with 39.3% being non-Latino white, 30.7% Latino, 18.4% Asian, 3.3% African-American, and the remainder of other ethnic groups. According to the census, about 40% of people in the county speak a language other than English at home. Many of the lowest income families are mono-lingual Spanish-speaking recent

immigrants from Mexico. Migration from Mexico continues as people come to the county to fill low wage jobs in the service sector. Often immigrants bring their families with them, and they and their children will not qualify for existing public insurance programs if they are undocumented.

The cost of living in San Mateo County is the highest of any county in California. While the percentage of people living below the federal poverty level is relatively small, the high housing cost takes resources away from other family basic expenses. Consequently, the county's Human Services Agency has recently calculated the self-sufficiency level for a family of four to be \$67,000 or 400% of the federal poverty level in 1999. Over a quarter of families in the county fall below that income level.

During the CHI implementation period, San Mateo County experienced a severe economic downturn with the service sector being particularly hard hit. The many small employers in the county have had a difficult time meeting the expense of employee health insurance. In many instances, this has led to more use of part-time workers (without insurance), greater requirements for employee cost-sharing than in the past, and/or the elimination of family coverage.

The economic downturn in the county is mirrored by a poor economy state-wide, leading to a severe budget deficit for the state, which has traditionally supported care for low income children through the Medi-Cal and Healthy Families programs. Indeed, the week of our site visit (October 6-10, 2003), the state's budget crisis led to a referendum by which the current Democratic governor, Gray Davis, was recalled and a Republican, Arnold Schwarzenegger, was elected. By the time of this report, Governor Schwarzenegger had proposed severe budget cuts to many health and human services programs, including a cap to Healthy Families enrollment and a 10% reduction in Medi-Cal payments to providers. It is still unclear what the final budget will contain and how it will affect the San Mateo County CHI.

Just before the recall vote, Governor Davis signed into law a landmark bill that will require California employers to provide health insurance coverage. However, very small employers (under 50 employees) will be exempt. We were told that larger employers usually

provide insurance in San Mateo County, so it is unclear at this time how much this will affect the rate of health insurance coverage.

Although there are six hospitals in San Mateo County,<sup>3</sup> the burden for care for uninsured people falls on the county's public hospital, the San Mateo Medical Center. Just outside of San Mateo County, the Lucile Packard Children's Hospital is also a major provider of pediatric services to low income children in the southern part of San Mateo County. In addition to these inpatient facilities, there are six county-operated pediatric clinics<sup>4</sup> and the Ravenswood Family Health Center, a federally funded clinic; all of these ambulatory care sites serve the uninsured and other low income people. We were told that many Latinos prefer public clinics, even when they are insured, because there is more language and cultural competency there than among private providers. There are also some free small clinics that play a more limited role in the provision of ambulatory care to uninsured children and their parents.

Another reason that San Mateo County safety net providers are serving so many low income people, including those with insurance, is that there is a shortage of private providers in San Mateo County, particularly pediatricians and dentists. We heard that those who retire are not being replaced one-for-one, so the shortage is growing. Consequently, those physicians who are practicing can easily fill up their practice with privately insured children, for whom payment rates are higher than for public programs.

In 1986, San Mateo County was the second California county to establish a County Organized Health System (COHS) to provide and manage health care to Medicaid beneficiaries on a capitated basis. The county established a non-profit entity, the Health Plan of San Mateo (HPSM), to administer the program. San Mateo is now one of five remaining COHS plans in the state. When Healthy Families was implemented, the HPSM became one option among others for Healthy Families enrollees to select. In December 2003, the HPSM had 46,622 Medi-Cal enrollees (with 20,785 being children) and 2,445 Healthy Families enrollees.

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<sup>3</sup> Mills-Peninsula (200 beds), San Mateo Medical Center (100 beds), Sequoia (120 beds), Seton Medical Center (200 beds), and two Kaiser hospitals, South San Francisco (120 beds) and Redwood City (209 beds).

<sup>4</sup> Daly City Youth Health Center; Belle Haven Community Health Clinic; Fair Oaks Family Health Center; 39<sup>th</sup> Avenue Clinic; North County Family Practice Clinic; and South San Francisco Clinic.

The welfare reform process of the late 1990s brought some changes in the relationship between the public sector and the not-for-profit sector in San Mateo County. During welfare reform, the county Human Services Agency funded several community based organizations (CBOs) to provide community support services that are critical to people transitioning off of welfare (e.g. alcohol and drug counseling, housing, child welfare). Some of the same non-profits have been able to assist the county in implementing the CHI, since they are in contact with many of the same families through their welfare reform efforts.

A final important contextual factor that explains how San Mateo County was able to rapidly implement the CHI is the history of collaboration and experimentation in the county. We were told that different agencies and organizations usually work well together, which facilitates cross-agency collaboration. San Mateo County's size facilitates its ability to do such experimentation, since it is big enough to have the administrative capacity and experience to develop new programs, and yet it is small enough for all the key players to know and trust one another.

## **HISTORY OF THE SAN MATEO COUNTY CHILDREN'S HEALTH INITIATIVE**

In the period 2001-2002, several factors converged and led to the establishment of the San Mateo County Children's Health Initiative. Momentum began with a paper that masters student, Toby Douglas (who later joined the Health Services staff), wrote to fulfill one of the requirements for his degree. This paper, completed in June 2001, examined the need for more active outreach and enrollment of children into available public programs. Around the same time, the county applied for and received a Community Access Program (CAP) grant from the federal government to address the problem of lack of health insurance. The CAP grant funded the salaries for several Community Health Advocates, who are dedicated to outreach and enrollment at clinics throughout the county. The CAP grant, which is still underway (although winding down), also supported the initial process of bringing together major players to discuss the system improvements needed to cover all children in the county.

Around the same time, the First 5 San Mateo County Commission-funded by California's Proposition 10 tobacco tax revenue to support health, education, and childhood development

among children ages 0-5—identified several new priorities that it might support, including broadening children’s health insurance coverage. County Supervisor Rich Gordon, who sits on the Commission, has a longstanding interest in health and children and pushed the commission to target children’s health insurance. There was a growing awareness that, with the county’s economic difficulties, many families were newly in need of coverage. There was also a growing awareness of neighboring Santa Clara and San Francisco counties’ newly-implemented Children’s Health Initiatives, which could serve as models. Finally, in terms of initiatives that would affect the lives of the most children, health insurance was considered to be a more viable option than the other major initiative under consideration—universal preschool—since universal preschool is much more expensive than universal health insurance.

A third parallel effort was the work of the Hospital Consortium of San Mateo, which also independently made the expansion of children’s health insurance a priority. The Hospital Consortium was formed in the early 1980s and includes all hospitals in the county, except the two Kaiser hospitals. One of the initial potential priorities of the Consortium was to extend health insurance to children. The Consortium had a retreat in December 2001, with the purpose of planning for 2002 and 2003. At this meeting, the board adopted a plan to work with First 5 and the Community Access Program on this important issue. The involvement of the Hospital Consortium was critical to obtaining financing from two hospital districts, as described below.

The First 5 Commission established a health access task force, led by Kris Perry and charged to develop a CHI implementation plan for presentation to the Commission in April, 2001. The group included Toby Douglas (Health Services), Liane Wong (Child and Family Technical Assistance Center), Kris Perry (First 5), Margaret Taylor (Health Services), Elsa Dawson (Human Services), and Glenn Brooks (Human Services). One of the issues that emerged from the work group was the need to quickly develop a new insurance product, “Healthy Kids,” to cover children living in families with incomes under 400% of the federal poverty level who are uninsured and ineligible for other government programs.

The participants in the work group continued to be key players in developing and implementing the San Mateo CHI. The group eventually expanded to include representatives from the Hospital Consortium, the Peninsula Community Foundation (PCF), the HPSM, and the Labor Council.

Several different informants told us that leadership was critical to early rapid implementation of the CHI. One person said: “Margaret Taylor’s can do attitude and graciousness helped bring people together to work on the CHI, and Toby Douglas has kept it moving along.”

To solicit broader community input, key partners decided to hold a county-wide “summit” meeting on children’s health insurance in May, 2002. The Hospital Consortium and Peninsula Community Foundation provided funds for the summit. The meeting attracted over 100 people, including representatives from Human Services, Health Services, labor, advocacy organizations, and political leaders such as the Hon. Jackie Speier and members of the Board of Supervisors. Commitments were made at the summit to proceed with a children’s health program, setting January 2003 as the target date for implementation. The next step was to identify funding sources (above and beyond the First 5 Commission commitment for the 0-5 age group). The summit was key to getting the important financial support of the county Board of Supervisors.

All told, the period from the First 5 discussions to the planning and design phase of the CHI took about one year. There was a short delay in obtaining a “material modification” in the Health Plan’s authority to offer the new insurance product, Healthy Kids. (This latter step took three months, which was considered to be very fast.) When the license was finally obtained, it was effective February 14, 2003.

The areas that were potentially controversial as the CHI evolved were the upper income level for coverage and the question of covering undocumented children for the Healthy Kids program. Some participants thought that providing health insurance for children up to 400% of the federal poverty level was too broad, and that some families in the higher income range might drop private health insurance as a result of the initiative (a phenomenon called “crowd-out”). Still, the key partners decided that the cost of living was so high in San Mateo County that Healthy Kids should cover children up to that level. This decision yielded a very unique dimension to the San Mateo CHI, as it is the only such initiative in the state to cover children at such a high income level. At the same time, political leaders told us that there was no political opposition to devoting county resources to cover undocumented children. The decision to cover these two groups (higher income children and undocumented children) may emerge as more

controversial issues for Healthy Kids in the future, however, if public programs such as Healthy Families—which cover low income documented children—become more limited.

Another underlying area of controversy, although not openly discussed at meetings, was the viability of the Health Plan of San Mateo (HPSM) as the means of administering the Healthy Kids insurance product. While the financial difficulties of the plan were not as evident when the program was first conceived in 2001-2002 (they became evident later in 2003), there was still some question about this choice of plans from some parties. However, we were told that the plan was ultimately chosen to be the administrative arm for Healthy Kids for three primary reasons: (1) the plan had a well-established, culturally competent network of providers; (2) using the HPSM made it possible for families with children with different forms of health insurance to have a single provider; and (3) it made financial sense for the county to use “one of its own”—a plan with a close link to county-operated health facilities—in contrast to another managed care organization with a different provider network.

In recent months, the financial difficulties of the HPSM have become more acute because state budget difficulties have led to a decision not to increase the premium paid to the HPSM for San Mateo County Medi-Cal enrollees. If additional state funding is not forthcoming, one "fall back" is for the county's Medi-Cal program to revert to fee-for-service reimbursement. If this should happen, the impact on access to care for Medi-Cal, Healthy Families, and Healthy Kids enrollees could be great. For example, if Medi-Cal patients are placed in a fee-for-service system, Medi-Cal provider reimbursement rates will decline substantially, potentially causing many providers to leave participation in public insurance programs. At the time of this report, the future of the plan remains uncertain. The way that the HPSM's financial difficulties are resolved could have significant implications for the CHI, and this situation will be followed closely in future years of the evaluation.

## **ORGANIZATION OF THE CHI**

The major goal of the CHI is to increase health insurance coverage for uninsured children in the county. The key partners established an explicit target early in the process: to enroll 14,600 uninsured children, with 9,250 being covered by Medi-Cal or Healthy Families, and the

remaining 5,350 covered by the new Healthy Kids insurance product. These targets were based on estimates from sample survey data (such as the California Health Interview Survey).

We heard about several additional goals for the CHI (though perhaps not as universally agreed to). These include: (1) to increase the utilization of preventive care among children; (2) to improve child health status and readiness to learn; (3) to mainstream poor children into a “community standard” of care; (4) to reduce total health cost for children; and (5) to improve the financial status of the public hospital system.

Shortly after the summit, the leadership of the planning group transitioned from First 5 to the Health Services Agency, and the planning group (minus the consultants) was renamed the Oversight Committee for the CHI. This group, established through a Memorandum of Understanding signed by all members, continues to serve as the governing board for the Children’s Health Initiative. The members are Margaret Taylor (Health Services), Maureen Borland (Human Services), Mike Murray (HPSM), Kris Perry (First 5); Bob Hortop (Mills-Peninsula Health Services – not a voting member); Francine Serafin-Dickson (Hospital Consortium); Srija Srinivason (Peninsula Community Foundation), and Shelley Kessler (San Mateo County Central Labor Council). Initially, the Oversight Committee met every two weeks, but now meets every two months, staffed by Toby Douglas. Committee members are not personally legally or financially liable for decisions, since there is no separate 501(C)(3) corporation set up to run the initiative. While not officially represented on the CHI Oversight Committee, the San Mateo County Board of Supervisors provided some legal basis for decision-making when it passed a resolution naming the Oversight Committee as the decision-making body for the CHI. To date there have been no real problems associated with this governance structure, but should any financial or legal difficulties arise in the future, the county Board of Supervisors is implicitly ultimately responsible.

There are six subcommittees of the Oversight Committee including: (1) Marketing; (2) Fundraising/finance; (3) Outreach/enrollment (a “coalition” including CBO partners); (4) Healthy Kids Policy and Procedures; (5) Evaluation; and (6) Provider Network Development. The subcommittees make recommendations to the Oversight Committee on the topics within their purview. The sub-committees meet at variable times. The Marketing, Fundraising, and Provider Network Development committees meet only as needed; the Outreach/enrollment,

Policy/Procedures, and Evaluation Committees meet at least monthly. Notably missing from both the Oversight Committee and sub-committee structure is involvement from the private medical and dental provider community. We heard that there have been attempts to involve them, but that so far these efforts have not been successful.

## **OUTREACH AND ENROLLMENT**

Since the major goal of the initiative is to enroll every child in the county into the health insurance program for which he or she is qualified, and since all uninsured children below 400% of poverty are potentially eligible for public health insurance, a major emphasis of the CHI has been to improve the outreach and the enrollment process for all public programs. Indeed, in San Mateo County, outreach and enrollment usually go hand-in-hand.

**Outreach Events and Publicity.** To kick off the Children's Health Initiative, in January 2003 the CHI partners sponsored three very large community health fairs at which people received information about the CHI and assistance in applying for public insurance. The events were advertised using radio spots and community canvassing (in churches, for example). At these events, 30 application assistants "took applications all day long." These initial enrollment events were reported to be extremely successful, and nearly 700 applications for public programs were completed in January 2003 (with enrollment for Healthy Kids being effective mid-February for those who qualified). The partners were surprised and pleased at the high level of interest in the program that was generated by these events.

The CHI continues to sponsor outreach/enrollment events, although the number of applications taken at subsequent events has been fewer. (On average 20-30 families are now enrolled at each event.) We obtained the calendar for "Community Enrollment and Informational Events" for the fall of 2003. Three locations were listed where screening and enrollment are regularly conducted (either weekly or monthly), as well as eight additional one-time events (mostly health fairs), occurring between September 20 and December 8. Given the extensive preparation required to sponsor such events, CHI partners now are considering reducing the frequency of outreach events. Altogether, the outreach and enrollment efforts

continue to generate 60-80 applications to Healthy Kids per week. Health Services has taken the lead in organizing these outreach activities.

The CHI has not emphasized mass media (such as television or radio spots) as a means of advertising, since partners feel that direct outreach is far more effective. The only real media efforts have been the developments of flyers and a web site, funded in part by in-kind contributions from the Hospital Consortium.

The CHI has a toll-free hotline for families to call with questions or concerns, staffed by Health Services staff. Hotline staff refer clients to the appropriate locations where they can enroll, and make an appointment for them if they want one. The hot line receives an average of 12 calls per day.

**School-Based Outreach.** Outreach also occurs in schools, although unevenly around the county depending on the school district. There are 18 school districts in San Mateo County, and it has been very challenging to involve all of them. Currently, 12 districts engage in some form of outreach and/or enrollment efforts for the CHI. Consumers Union was instrumental in initiating these processes.

The primary vehicle for school-based outreach is the Request for Information (RFI). RFIs are designed to identify parents who are interested in being contacted to gain information about health insurance options for their children. The RFI goes home with children from school, typically along with applications for free and reduced price lunches (sometimes along with other information, such as Back-to-School packets and report cards) and is returned to school. Parents who request assistance are referred to an application assistor who follows up with them, usually by setting up an appointment at an enrollment site for application assistance.

In addition, the Redwood City school district is currently a pilot school district for Express Lane Eligibility, along with school districts in Alameda and Santa Clara counties. Express Lane Eligibility connects the school lunch enrollment process directly to Medi-Cal eligibility and enrollment electronically, by taking the existing school lunch application and adding questions to screen for Medi-Cal eligibility. If the child is eligible for the free lunch program, is not on Medi-Cal, and requests to be enrolled, Human Services enrolls the child in

Medi-Cal presumptively. The California Endowment funds the Express Lane Eligibility pilot program in Redwood City.

**Outreach Workers.** There are several types of workers who are involved in outreach and enrollment, although the categories overlap in some situations:

- *CAAs:* Certified Application Assistors (CAAs) are trained for one day by the state’s training contractor and subsequently are certified to help families enroll in Med-Cal and Healthy Families. Individuals who receive this training are then eligible to receive Healthy Kids application assistance training. There are 130 CAAs in the county and some reported to us that this number is not sufficient. The salaries of these individuals are covered by the organizations for which they work; in some cases the CHI supports them through CBO outreach grants.
- *Outstationed CHAs:* Community Health Advocates (CHAs) are employed to work as application assistors, and they also are certified as CAAs. Currently, there are five Health Services’ CHAs, outstationed in various community-based locations such as schools and free clinics, who co-ordinate school-based outreach and outreach/enrollment events. These individuals are employees of Health Services, and their salaries are covered by the CHI.
- *San Mateo Medical Center CHAs:* Another 10 CHAs are employed by the San Mateo Medical Center. Seven of them work in public clinics and the others work in the inpatient portion of the hospital. All medical center CHAs work exclusively among center patients. (Their salaries are covered by the medical center, not the CHI).
- *BAs:* Benefits Analysts (BAs) are the fourth type of worker. These individuals are employed by Human Services, and have traditionally done a variety of types of case work including final eligibility determination for Medi-Cal. They now do Healthy Families and Healthy Kids enrollment as part of their regular work. Most, but not all, BAs who do enrollment have been through the CAA training as well. Their salaries are covered by Human Services.

While outreach events are important, another key method of identifying children who need health insurance in San Mateo County has been “in-reach,” whereby children are identified when they come to health and social services sites for other reasons. According to the first annual report from the CHI to the Peninsula Community Foundation, 42 percent of children enrolling in the Healthy Kids program have been enrolled by medical center CHAs, 16 percent by Health Services CHAs, 11 percent by Human Services BAs, 22 percent by CAAs at the CBOs that receive CHI outreach grants, and the remainder by other CAAs in the county. It is very

likely that the mix is different for children enrolling in Medi-Cal and Healthy Families, but statistics are not available. Still, “in-reach” remains important for all three programs.

CHAs are well regarded and viewed as effective by those we interviewed. We were told they are “passionate about their work” and “want to go beyond the insurance thing” to help families. Almost all are bi-lingual (English and Spanish).

It is to the county health system’s advantage financially to have active in-reach. For example, before the CHI and the use of CHAs, the county hospital was obliged to pay for all ambulatory specialty care for children who were screened by primary care providers through the Child Health and Disability Prevention (CHDP) program and identified as having a health problem that needed treatment. If a family came to a hospital clinic with a “hot-pink registration form” from a CHDP provider, state law required that the county hospital treat them. Prior to the CHI, there was no source of state reimbursement for this care for undocumented children. Now the hospital can be reimbursed by Healthy Kids for the services that it previously provided on an uncompensated basis.

While in-reach has been very productive in the first year, we also heard some questions about the effectiveness of this strategy in bringing new children to preventive health services. Some of those that we interviewed acknowledged that, to an unknown extent, the Healthy Kids program is a means of underwriting the cost of the county health care system by bringing in new sources of funding for services that were already being provided. (The evaluation’s impact analysis will examine this issue.)

The partnership with CBOs and with Human Services is designed to overcome this problem and reach children who are not yet served by the health system.<sup>5</sup> CBO CAAs and Human Services BAs incorporate outreach and enrollment into their regular interactions with families, which are generally for other purposes such as helping the families with childcare, housing, jobs, and other support. Sometimes CBO volunteers also are involved in outreach. For example, volunteers may make phone calls or assist at health fairs.

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<sup>5</sup> The contracted CBOs are: North Peninsula Neighborhood Service Center, Cabrillo Unified School District, Ravenswood Health Center, the Child Care Coordinating Council, Redwood City Family Center, the California Health Initiative, and the San Mateo Central Labor Council.

This form of outreach is less productive than clinic in-reach, in terms of the number of children enrolled per worker. CAAs from the CBOs told us that they are enrolling about 20-30 families each per month, and an outreach report showed very wide variability in numbers of families assisted by site and by person. For example, among the contracted CBOs, the number of families receiving enrollment assistance varied from 97 to 488 across calendar year 2003 (or from 8 families to 40 families per month). Some informants expressed the opinion that CBO outreach is less productive, because most of the CBOs are not regularly working on health care issues. “They had to be persuaded to put health insurance on their agendas.”

However, it is perhaps unfair to use the same productivity standards for “in-reach” and the outreach through CBOs, that is designed to find the hardest to reach group. Line staff of CBOs themselves told us about the barriers they face to enrolling families in health insurance. For example, CBO staff keep regular office hours, but families are often at work and cannot come in for appointments. The families also move often and may not have telephones, making regular contact difficult. They may not have ready access to transportation. When the CAAs make home visits, they cannot easily complete the health insurance application in a home setting because much of the documentation has to be copied. They also said that it is very tough when you can offer children health insurance, but not their parents.

There is a considerable amount of networking and information sharing among all the different types of CHI outreach workers, fostered by the monthly meetings of the CHI Outreach/enrollment Coalition. The meetings are organized by Health Services to share information about enrollment events and offer training. The CHAs and BAs also have monthly regional meetings to discuss specific cases. Finally, individual training is regularly provided to CBO staff, in order to provide more personalized technical assistance.

## **THE HEALTHY KIDS PROGRAM**

In addition to outreach and enrollment, the other major component of the CHI is the Healthy Kids program, a managed care plan for previously uninsured children who are not eligible for any other form of insurance. As mentioned, all Healthy Kids are enrolled in the HPSM, and thus do not have a choice of plans (as they do with Healthy Families). However, the

HPSM provides potential access to a broad provider network through its contracts with providers throughout the county.

**Enrollment Process for Healthy Kids.** Healthy Kids enrollment is not currently closely tied to enrollment in other public programs, although there is continued movement in that direction. At the time of our site visit, Healthy Kids used its own, simplified, hard copy application that must be completed with the help of an application assistor, who then sends it to Human Services once it is signed. Unfortunately, this means that families must complete more than one application if they learn that they do not qualify for Healthy Kids.

There is a goal to eventually develop a joint application, and this process will be coordinated with a pilot program called the One-e-App. Three bay area counties — San Mateo, Alameda, and Santa Clara — are working together to implement this on-line enrollment system. In order to have a single system for all three counties, the counties must develop a common data set for the on-line system, which is very challenging since forms for county-based programs such as Healthy Kids are different from county to county. Currently, One-e-App implementation in San Mateo County is limited to the Healthy Kids’ program and, at the time of our visit, was in its earliest stages.

During the first several months of the Healthy Kids program, Human Services used a “home-grown” database to store Healthy Kids application and enrollment data. Then On-e-App implementation began in June 2003, at which point there was a gradual process to shift both previous and ongoing Healthy Kids application and enrollment information into the One-e-App system.

In the limited circumstance in which it was operating at the time of our visit, the One-e-App process was as follows: CHAs submitted applications electronically to Human Services for review, along with the associated faxed attachments. Human Services staff then determined eligibility, a decision that was automatically transmitted to the health plan. The hope is that,

eventually, Medi-Cal and Healthy Families applications will also go into the same system, which will automatically transmit them to the single point of entry, MRMIB.<sup>6</sup>

Until the One-e-App is implemented countywide, a manual system also is being used whereby hard copy applications for Healthy Kids are sent to Human Services, which inputs the data into the One-e-App system to make an eligibility determination. Human Services also collects the premium. Enrollment data are transferred electronically to the HPSM where the information is downloaded into a special Healthy Kids membership database. Eligibility begins 10 days after the health plan receives all information from Human Services. The plan then sends a packet with the Healthy Kids insurance card to the family. The whole process from application to plan enrollment used to take 4-6 weeks (due to the high volume of applications early in the program and the lack of an established system), but the time frame is shorter now. The Healthy Kids membership database is used for tracking, producing ID cards, sending reminder letters for re-enrollment, and invoicing for premiums.

According to some, this enrollment process, which involves multiple agencies and data bases, has led to higher than necessary costs and delayed enrollment. However, others said that the early glitches have been smoothed over and that the system works well now. One observer commented that—in general—the cross-agency collaboration fostered by the CHI has increased the complexity of some processes, and that this has both positive and negative consequences. The positive benefit comes from the fact that several partners are now working closely together in ways that they have not in the past, but this is offset by some loss of efficiency.

**Benefits.** Healthy Kids benefits are designed to be similar to Medi-Cal, and especially to Healthy Families, in order to provide a “seamless” form of insurance for children who move from program to program and/or for families with children in different programs. Healthy Kids has a relatively generous benefit package (when compared to many private plans), which mirrors that of Healthy Families and covers the following services:

- Medically necessary hospitalization

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<sup>6</sup> MRMIB is the state agency that administers Healthy Families. The One-E-App, which incorporates applications for county-based programs and other human services programs such as Food Stamps, will intersect with the Health-e-App, an automated application system for Medi-Cal and Healthy Families.

- Physician, outpatient, and surgical services
- Prescription drugs
- Well child services
- Family planning
- Mental health
- Occupational, alcohol, and drug treatment services
- Physical and speech therapies
- Lab and X-ray services
- Dental and vision services

The monthly premium paid to the HPSM is \$95.25 per child. Parents pay a share of the premium, which is collected by the HPSM and held in a separate fund to be returned to the CHI to cover future Healthy Kids premiums. The portion paid by the family depends on family income, and ranges from \$4 to \$20 per child per month. Parents pay the premium quarterly, or if they desire they may pay for a whole year and receive 3 free months. A high proportion of families (60%-70%) elect to pay annually and receive the discount. There is also an assistance program that—while not widely publicized—is reserved for extreme hardship cases. Human Services waives the family premium when the family simply cannot pay it. In those circumstances, Health Services pays HPSM the whole cost of the premium.

Parents also pay a \$5 co-pay for their children’s visits and prescription drugs. There are no co-pays for preventive care, and there is a maximum of \$250 per year per family in co-payments.

**Healthy Kids Provider Network.** All public and non-profit providers participate in the Healthy Kids provider network and, based on a review of the plan’s provider list, a large number of private providers are also listed. There are 26 pediatric practices on the Health Plan of San Mateo's provider list, some of which are solo practices and others that are medium and large group practices. There are another 18 family medicine practices, again including solo and some larger group practices. However, the extent of the private provider network remains unclear to us, because we heard conflicting reports from those we interviewed about actual access to the

listed providers. We were cautioned that many practices are closed to new patients, even those that are not so designated in the provider list, so these numbers may not represent the true scope of providers available to low income pediatric patients. Since we heard that the majority of children who have been enrolled in Healthy Kids have been identified through community and medical center clinics, access to private providers may not be an issue for the majority of current enrollees. As a result, the true availability of services in the private sector may not yet have been tested. Access to private primary care and specialty care networks will be further explored in the provider analysis component of the evaluation, to begin next year.

**Ongoing Follow-up with Members.** Up to now, there has not been a lot of emphasis on following up with families after a child is enrolled in Healthy Kids. An eligibility coordinator at the health plan may interact with families of Healthy Kids enrollees soon after enrollment, for example, in order to assign a primary care provider (PCP) if there is none. If the eligibility coordinator cannot reach the parent, she sends a letter, and then if there is no response, she “auto-assigns” a PCP who lives near the family and speaks their language. This coordinator does not work with families on how to “use the system.” That is the responsibility of plan member services. For example, member services will invite the family to the educational programs that the plan offers (although there is no follow-up to assure that they attend). Up to now, HPSM has not made welcome calls to new Healthy Kids members or placed an emphasis on identifying children who are not using services.

## **FINANCING THE CHI**

The financing of the San Mateo County CHI is complex and involves multiple input and output streams. Given the greater than expected enrollment in the program, it has been very challenging to find sufficient funding.

**Inputs.** On the input side, the budget for calendar year 2004 is \$7,775,000, with firm contributions coming from First 5 (\$1.75 million); San Mateo County general revenue (\$2.7 million); Sequoia Healthcare District (\$1.35 million); Peninsula Healthcare District (\$.68

million); and various foundations (\$1 million). This leaves a projected deficit of \$.24 million that the CHI is still working to cover. These funding sources are used to fund all of the activities associated with the CHI described above, such as outreach and premiums for Healthy Kids enrollees.

Unfortunately, much of the funding comes with some restrictions on how the money can be used, which creates additional challenges. For example, First 5's commitment must be spent on children under age 6, resulting in under-spending to date of the funds that are potentially available.<sup>7</sup> The two hospital districts (Peninsula and Sequoia) only cover expenses (eg. outreach and premiums) for children 6-18 in their particular hospital districts. Much of the foundation support is for non-premium expenses, although the California Health Care Foundation recently committed a substantial amount (\$500,000) for premiums.

**Outputs.** The funds for the CHI are used in two primary ways: to pay premiums to the health plan for Healthy Kids enrollees, and to cover the costs of outreach, enrollment, and marketing activities; eligibility determination; evaluation; and project administration.

In terms of premium payments, in 2004 the CHI currently has sufficient funding to cover 67,690 member months (an average of 5,641 enrollees per month) at \$93.25 per child per month. The total projected CHI expenditure "in hand" for premium support is thus \$6,312,250. However, the CHI would like to cover all children who apply, and has estimated, for that to be so, that another \$257,750 is needed to cover an additional 2,764 member months, or just over 230 more children. Consequently, the total budget for premiums is \$6,570,000.

The remaining portion of the calendar year 2004 CHI budget (\$1,185,000) is to be used for the following purposes:

- *Eligibility Determination.* Two full time staff positions at Human Services to perform eligibility determination and One-e-App maintenance, paid by Health Services through a Memorandum of Understanding between the two agencies. (\$190,000)
- *Health Services CHAs:* Five outstationed CHAs and their supervisor, employees of Health Services, who also assist in coordinating outreach and enrollment activities and staff the hot line. (\$385,000)

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<sup>7</sup> Additional First 5 funding is available (up to \$2.3 million, total), but this can only be used to cover expenses for 0-5 year olds, so the budget estimates an expenditure of only \$1.75 million. The Commission has two options regarding how to dispense with the remainder: (1) a no-cost extension to the CHI based on a revised budget, or (2) using it for another (non-CHI) purpose. As yet, no decisions have been made about these options.

- *CBO Grants:* Grants to 7 community based organizations from Health Services for outreach. Grants range in size, at an average of \$25,000 per CBO. (\$170,000 )
- *Marketing:* covering the cost of advertising materials. (\$60,000)
- *Project administration:* covering the cost of Health Services CHI staff. (\$130,000)
- *Evaluation:* covering the cost of the evaluation contract. (\$250,000)

The flow of funds through the different entities involved is especially complicated. The Peninsula Community Foundation (PCF) collects all the money from the two hospital districts<sup>8</sup> and foundations (about 40% of the entire funding base).<sup>9</sup> Health Services holds the funds from the county and from First 5. First 5 pays for one third of all non-premium costs, and for all the premiums for children under age six.

The flow of funds is regulated by multiple contracts. First 5 has one contract with Health Services (\$2.3 million) for premiums and non-premium activities for the 0-5 age group.<sup>10</sup> The PCF has another contract with Health Services that similarly funds some of the expenses for the 6-17 age group. In addition to its contracts with CBOs for outreach, enrollment and retention services, Health Services also has a contract with the HPSM to administer the Healthy Kids program for children aged 0-18. Each quarter, the HPSM sends two invoices to Health Services for all premiums for the quarter, a "retrospective invoice" reflecting the true experience of number of children enrolled, and a "prospective invoice" reflecting the estimated experience in the coming quarter. If a smaller number of children are enrolled than anticipated, the remainder from the completed quarter is subtracted from the prospective payment they are entitled to for the coming quarter. Health Services then bills either First 5 (for premiums for the 0-5 group) or the PCF (for premiums for the 6-18 group). The plan cannot be reimbursed until all of this billing has occurred.

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<sup>8</sup> The hospital districts of San Mateo County are somewhat unusual entities formed to provide local communities with taxing authority to subsidize care in certain parts of the county. The districts own land and lease it (at little cost) to Mills-Peninsula and Sequoia hospitals (now owned by chains). They also collect property taxes to subsidize care.

<sup>9</sup> Having the PCF as the key holder of private sector money allows the CHI to receive funding from organizations that may only fund 501-C-3 organizations. Learning from the experience of the first year, the CHI is simplifying processes for invoicing and funds transfers for 2004.

<sup>10</sup> In the past First 5 had two contracts—one with Health Services and one with the HPSM. For calendar year 2004, these have been consolidated into a single contract with Health Services.

Because of the expected shortfall in the budget for FY 2004, the CHI has recently hired a part-time fundraising consultant who will be supervised by the Hospital Consortium and funded by a small foundation grant (\$16,800). This individual will provide developmental and organizational consulting services to recommend the most effective fundraising strategies for the Children's Health Initiative, in order to meet the funding gap for 2004 and future years.

## **EARLY EXPERIENCE WITH THE CHI**

The San Mateo County Children's Health Initiative has just completed its first year, and it is too soon to know what its full impact on children, health care providers, and others in the county will be. This section presents a very early look at some preliminary indicators of progress to date, organized according to the evaluation research questions being addressed in this first year report.

Since the CHI is sponsoring intensive outreach and enrollment efforts, we first examine the growth in applications for enrollment and actual enrollment in public health insurance programs since the CHI began. We also compare the characteristics of enrollees, use of services, and cost in the Health Plan of San Mateo across all three programs: Healthy Kids, Healthy Families, and Medi-Cal. (These enrollees constitute all children enrolled in Healthy Kids and Medi-Cal, but only a portion—the majority—of enrollees in Healthy Families.) These demographic characteristics are based on data provided by the plan for a cross-section of enrollees during the six-month period mid-February, 2003 to mid-August, 2003. We also provide utilization and cost data for a sub-set of enrollees in all three programs – those continuously enrolled from mid-February to mid-August. Finally, we provide some initial data on trends in care for uninsured children and uncompensated care at San Mateo County hospitals, as a way of looking at how the CHI may have affected area hospitals.

### ***Did health insurance coverage change for children in San Mateo County?***

A key part of the CHI's approach to increasing health insurance coverage is to cover new populations of uninsured children through the new Healthy Kids program. In its early months, the CHI achieved rapid enrollment growth in Healthy Kids. According to a memo provided to

the Oversight Committee on June 6, 2003, by that date the CHI had enrolled 2,584 children into Healthy Kids, far exceeding its six-month target of 1,200 children and surpassing its year one goal of 2,200 Healthy Kids members.

Rapid enrollment growth continued throughout the first year. By January 2004, 4,893 children were enrolled in Healthy Kids. The number of children enrolling each month has varied, with enrollment being highest in the first two months, when outreach was most intense, and in August and September (associated with back-to-school outreach).<sup>11</sup> Because of this rapid enrollment, the Oversight Committee anticipates that Healthy Kids may reach its enrollment limit in summer 2004, at which point a waiting list will be created for children ages 6 and older. (All younger children will be enrolled, because there are ample funds from First 5 for this group.)

Since the CHI seeks first to enroll children in either Medi-Cal or Healthy Families, and only to enroll children in Healthy Kids if they are ineligible for the other programs or for private insurance, we also examined the growth in enrollment in the other two public programs. (There are no data on private insurance enrollment.) At the beginning of 2003—prior to the initiation of CHI activities—there were 5,683 San Mateo County children enrolled in Healthy Families and 21,454 children enrolled in Medi-Cal. By July 2003—the period of intense outreach activity that led to rapid growth in Healthy Kids enrollment—the two other programs enrollment levels were 6,649 (H.F.) and 20,151 (M.C.) respectively.<sup>12</sup> That is, Healthy Families grew by 17% during the first six months of 2003 (which is identical to the growth rate in the same period for the previous year), and Medi-Cal enrollment actually declined slightly.<sup>13</sup> Consequently it is not a straightforward conclusion that the CHI led to growth in Healthy Families and Medi-Cal enrollment. On the other hand, it is possible that—with cuts in state Healthy Families outreach—Healthy Families' growth might have actually been lower without the CHI. Also, we heard of some improvement in employment in the San Mateo County service sector in 2003; this could be one reason for the Medi-Cal enrollment declines.

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<sup>11</sup> Information from handouts at the January 28, 2004 Oversight Committee meeting.

<sup>12</sup> Information from handouts at the October 22, 2003 Oversight Committee.

<sup>13</sup> The apparent Medi-Cal enrollment decline could be an artifact. The county was experiencing a backlog in the Medi-Cal recertification process during 2002 that was cleared up in early 2003, leading to numerous families being dropped from the roles.

It could be that some Medi-Cal and Healthy Families eligible children are erroneously being enrolled in Healthy Kids, although we have no firm evidence of this problem. Based on some limited observations of the enrollment process, we found that some CAAs may find it easier to enroll children in Healthy Kids than in the other two programs. Also, parents may request Healthy Kids because they view it as preferable to private insurance or another public program. In any case, it seems important for the partners to consider whether outreach efforts could place more emphasis on getting children on to the other two public programs or to private insurance programs.

At the time of our visit, there had been few terminations among those enrolled in Healthy Kids, and the renewal process for the first enrollees had not yet begun. As of January 28, 2004, 290 children had been terminated, 24% of whom had moved; 37% failed to make premium payments, possibly because they moved; 11% had other insurance; and 28% “aged out” (turned 19). Once children are dropped they cannot re-enroll for 6 months (which is consistent with the Healthy Families policy). Consequently, it is too early to tell whether discontinuous enrollment will be an issue for the Healthy Kids program. There is no recent data on continuity of enrollment for San Mateo County children enrolled in Medi-Cal or Healthy Families.

It is also too early to know whether the CHI has reduced the number of uninsured children in the county. Data provided below on the number of uninsured children served by the county medical center suggest that there continue to be uninsured children using services there.

### ***Who is served by the San Mateo County CHI?***

Table 3 provides some statistics on the demographic characteristics of Healthy Kids enrollees in comparison to Healthy Families and Medi-Cal children enrolled in the HPSM. Data are shown for all children who were ever enrolled in one of the programs during the period February through November 2003. As shown, both Healthy Kids and Healthy Families children are similar in age, with about 20% of children in each program being under age 6 and close to a third being adolescents. This is very different from the Medi-Cal age distribution, in which almost half are under age 6. This could be due to Medi-Cal’s broad coverage of infants, and the fact that most infants are born as citizens and therefore documented. Also younger families, with younger children, are poorer and more often qualify for Medi-Cal than for Healthy Families. The

gender profiles for all three programs are very similar, with slightly more boys enrolled than girls in each (data not shown).

The remaining characteristics provided for Healthy Kids enrollees are not available for the other two programs. As shown, about 80% of Healthy Kids enrollees have Spanish as their primary language, the majority have incomes below 150% of the poverty level, and fully 92% are undocumented as reported in the database.

***What services did Healthy Kids enrollees receive as part of the initiative? Did the CHI affect access to care for children who enrolled? Did the CHI affect where services were received?***

Since the purpose of enrollment in health insurance is to give children new access to health services, we also present some very early results on the health services that the first group of Healthy Kids enrollees received under the plan during their first six months of enrollment, in comparison to health service use for Medi-Cal and Healthy Families children in the HPSM during the same period (Tables 4 and 5). Data are presented only for continuous enrollees for the period mid-February 2003 to mid-August 2003 (the first six months of the Healthy Kids program.) This is done in order to provide comparable measures across the three programs. Since enrollees were being added steadily to Healthy Kids throughout the first year of the CHI, it would not be valid to compare rates of service use for varying periods of enrollment. With the measures shown, we are able to compare service use with a common denominator of six months of continuous enrollment.

In order to obtain a “benchmark” against which to compare the rates for San Mateo County, we sought national-level data that were readily available, and provide them in the tables. Note that the national data are provided for a full annual period, while the San Mateo County utilization are available for only six months, so any comparison should be made with that in mind. Next year we will be able to compare full year rates from the health plan to national data, as well as data obtained for a sample of children in the evaluation’s client survey.

As shown in Table 4, preventive care was apparently relatively low in the first months of the Healthy Kids program. Only 16% of the 532 Healthy Kids who enrolled in February, and were continuously enrolled for six months, had a preventive care visit during their first six

months on Healthy Kids. Rates of preventive care visits were also relatively low for the other two public programs: 21.7% of Healthy Families children had a preventive care visit and 27.4% of Medi-Cal children had a preventive visit in the same period. While the proportion of children receiving preventive care in all three programs seems low, the percentage for Healthy Kids seems particularly low. Relatively soon after enrolling in the program, families should bring their children in to see a doctor for a check-up, particularly since these children were uninsured prior to enrolling. It is worth following this pattern closely over the next year. The low rate of preventive care could be a signal that the CHI needs to direct more resources towards educating parents about the importance of obtaining preventive care for their children.

Much of the preventive care was provided at public and non-profit clinics for all three programs. 12.6% of all Healthy Kids enrollees received at least one preventive visit at a clinic, compared to 9.9% of Healthy Families enrollees and 16.9% of Medi-Cal children. Only 4% of Healthy Kids were reported to visit other doctors for preventive care; use of other (non-clinic) physicians was more common for Healthy Families and Medi-Cal enrollees.

Table 4 also shows the use of other ambulatory care, including primary care and specialty care. A substantially higher percentage of children enrolled in Healthy Kids had at least one office visit to a clinic for non-preventive care (37.1%), similar to rates for Medi-Cal (35.4%), and Healthy Families (31.4%).

A generally-accepted measure of access to care is the percentage of children who have at least one ambulatory care visit during a given year. During 2000-2001, about 87% of U.S. children under 18 had at least one ambulatory visit. We examined the percent of children who had at least one ambulatory visit reported in the HPSM administrative data over six months, and found that slightly over half of children in all three programs had a visit. Since this is for only six months, it is very possible that children in these programs have relatively high rates of ambulatory visits on an annual basis, when compared to all children nation-wide.

There are several caveats to be aware of when considering these results. First, the rates have not been adjusted for differences in case mix in the different groups that are being compared. Also, it is very possible that some children receive preventive care (a health check-up or immunizations) at the time of other visits to their ambulatory care provider. (The HPSM has found that adolescent preventive care is substantially underreported in administrative data,

compared to chart reviews.) In addition, children may have had an ambulatory visit at the time they began the enrollment process for HK. This visit would not be covered by the program or counted in these statistics. Thus, we are likely undercounting ambulatory care visits, especially preventive care visits.

Only a small proportion of Healthy Kids enrollees used the emergency room in their first six months on the program (5%), which is a sign that when they are obtaining health care it is in more appropriate locations. Use of the emergency room was higher for children in Healthy Families and especially high for children in Medi-Cal. It is certainly possible that these differences in rates could be due to differences in the case mix of children in each program. For example, Medi-Cal children may have higher rates of asthma.

The national percentage of children under the age of 18 with 2 or more visits to an emergency room in 2001 was 6.8%. While a six month rate cannot directly be compared to a 12 month rate, for a rough comparison we doubled the proportion of children in Healthy Kids with 2+ visits (1.4%), a percentage substantially below the national average. A similarly constructed one-year estimate for Healthy Families (5.4%) also falls substantially below the national average. However, the Medi-Cal rate (10.8%) is substantially above the national benchmark. Again, following this same cohort for another six months will yield a more accurate comparison to the U.S. benchmarks.

Rates of hospitalization appear to be low for all three programs. Less than one percent of Healthy Kids enrollees were admitted to the hospital in their first six months of enrollment, with a similarly low rate for Healthy Families and only slightly higher rate for Medi-Cal. This compares to about 4% of children who are admitted in a year nationally. In comparing rates across the three programs, we should consider that some of the Healthy Kids and Healthy Families enrollees may be covered for some visits and hospitalizations by “Emergency Medi-Cal,” prior to enrollment in H.K. or H.F. If so, this would artificially inflate the rates for Medi-Cal and suppress the rates for the other two programs. In addition, the apparently low overall rates of ER use and hospitalizations among publicly insured children in San Mateo County could, as with the ambulatory care comparisons, be due to some underreporting in administrative records, biasing the comparison to U.S. survey data.

***Did the CHI affect the cost of care?***

Table 6 shows the average expenditure per child for various services and in total. Data are provided for six months for children enrolled in February 2003 who remained enrolled continuously for six months. The average cost per child was \$223.93 for six months, or \$37.32 per month as reported in the administrative data. Interestingly, the largest expenditure per service for Healthy Kids was for dental care, about \$110 per child for the six months. This demonstrates a possible pent up demand for dental care for Healthy Kids enrollees. (Unfortunately we did not have reliable data for dental service utilization, although we hope to have those data in a later report.)

According to aggregate statistics, Healthy Kids enrollees appear to be more expensive than Healthy Families enrollees (\$146 total expenditure for six months) and substantially less expensive than Medi-Cal children (\$332.43 total expenditure for six months). However, these comparisons are biased because the Healthy Families data exclude vision and dental expenses, and Medi-Cal data exclude dental expenses. After excluding vision and dental expenses, Healthy Kids are the least expensive group, followed by Healthy Families, followed by Medi-Cal.

The average annual expenditure for health care per child aged 6-17 in the United States in 1999 was \$1022. (The rate for younger children was very similar—data not shown). Since this rate has not been adjusted for health care cost inflation, publicly insured children in San Mateo County appear to be much less expensive than the average child nationally.

***Did the CHI enhance the delivery and stability of the community health care system?***

The CHI was designed to provide a more stable financing base for the public and non-profit providers of health care to low income children in the county. We obtained information on trends in care for uninsured children and uncompensated care for children from the hospitals that are members of the Hospital Consortium. We requested the number of hospital admissions, emergency room admissions, services, and uncompensated care by payor (Healthy Kids, Healthy Families, Medi-Cal, and uninsured) for children 0-18. Because of data incompatibility we have included data from only three hospitals in this first annual report. We hope to expand the data that are available for next year's report.

Table 7 shows trends in emergency room visits for two hospitals, for the three public programs and uninsured children from 2001 to 2003. By fiscal year 2003, following implementation of the CHI, there continued to be emergency room visits for uninsured children, although there was a decline in the frequency of these visits from 2001 to 2003. There was a similar pattern for hospital stays for three hospitals (Table 8).

Table 9 shows trends in total revenue and uncompensated care for children at the Medical Center. Revenue for low income children (those covered by the three public programs and the uninsured) climbed from 2001 to 2003. From 2001 to 2002, uncompensated care also grew, but this pattern was reversed from 2002 to 2003. Much of the decline came from a reduction in uncompensated care for Medi-Cal children (probably not related to the CHI), but there was also a decline in uncompensated care for uninsured children (data not shown).

These preliminary statistics are potentially promising, since the CHI was very new during the period studied. (Data are through fiscal year 2003, which runs from July 2002 to June 2003, just six months into the CHI implementation period.) Still, it is too soon to attribute a strong affect of the CHI on the finances of the medical center or other hospitals. It will be important to continue to watch these trends in the coming years of the evaluation.

***Has the CHI increased community-wide collaboration to address issues of the uninsured?***

Our process analysis found that San Mateo County has a high degree of cross-agency and cross-county collaboration. While this collaboration was a precursor to, and indeed led to, the CHI, it also appears to have been strengthened as a result of the CHI effort. Particularly noteworthy is the successful collaboration between the Health Services and Human Services agencies that, in many parts of the country, do not work well together at either the state or local level. This collaboration has clearly contributed to the success of the CHI, but it has produced some challenges, largely in terms of the added complexity of finances and enrollment processes.

## **CONCLUSIONS FROM THE EVALUATION OF THE FIRST YEAR OF THE CHI**

This first annual report comes very early in the evaluation, and it is unwise to draw any firm policy conclusions from such preliminary findings. However, we here provide the partners with some preliminary views regarding how the CHI is meeting its primary goals.

**Health Insurance Coverage.** The high rate of enrollment growth following the implementation of the San Mateo County CHI is a reflection both of the pent up demand for children’s health insurance by low income uninsured children in the county, as well as effective outreach to find and enroll them. Enrollment in the Healthy Kids program far exceeded anticipated levels during this first year, and we conclude that “in-reach” in clinics, as well as intensive school and community outreach, were very good approaches to enroll the Healthy Kids target population. This successful outreach for Healthy Kids is a product of intensive and sustained collaboration among the CHI partners. The continued presence of uninsured emergency room visits and hospital stays at area hospitals shows that there are still uninsured children in need of health insurance in the county.

The effect of the CHI on Healthy Families and Medi-Cal enrollment is less clear, given changes in those programs and the economy of San Mateo County. Still, since Healthy Families enrollment continues to follow a strong growth path, it appears that CHI outreach is also important in sustaining that program’s enrollment growth. For obvious reasons, it is important to make certain that uninsured children who are eligible for Medi-Cal or Healthy Families are enrolled in these programs, so we recommend that the “screen and enroll” process be monitored periodically to ensure that limited Healthy Kids dollars are reserved for children ineligible for other programs.

Looking to the future, it remains to be seen whether the CHI can achieve its goal of universal health insurance coverage for low income children in the county. Several external factors—such as the limited budget for the CHI, a possible cap in the Healthy Families program, and possible declines in private insurance coverage—provide great challenges. These and other external factors will be important topics for study in later years of the process evaluation.

**Use of Services and Access to Care.** Data to address this very important set of issues were limited in the first year of the evaluation. While use of preventive care appears initially to be low for all three public programs, on closer examination we found that more than half of the children enrolled in them had at least one ambulatory care visit within the first six months of the CHI. Following the same cohort (those enrolled in February 2003) for another six months will show whether all, or most, children have at least one ambulatory visit in the first year of Healthy Kids enrollment, which would be a very positive indicator of access to care. The process analysis showed that many of the early enrollees in Healthy Kids were identified in clinic settings, so high use rates are perhaps expected for this early cohort.

Other tentatively positive indicators of ambulatory care access are low rates of emergency room and hospital use, especially among Healthy Kids enrollees. It will be important to monitor use over time to determine whether these initial patterns reflect stable long-term patterns, or whether they reflect initially low use of services by a newly-insured group. It will also be important to further understand the relatively low proportion of children receiving preventive care, to determine whether it is merely a data artifact reflecting how visits are coded, or whether it indicates a need for parental education about the importance of preventive care. While we did not have complete data on dental care use for this first annual report, we hope to monitor that care closely in future reports.

**Cost of Care and Stability of Public Health Financing.** Based on data provided by the health plan, it appears that publicly insured children in San Mateo County are less expensive than national norms in terms of program expenditures, and that Healthy Kids enrollees are especially inexpensive. Until data are collected in the year three round of the client survey, it will not be apparent whether the cost of care is lowered with the CHI, or whether there has been a shift in the burden of paying for that care. Initial data from the San Mateo Medical Center show a moderate trend downward in uncompensated care for children following the CHI. Given declining federal and state dollars for local health services, the CHI may help to stabilize the financing of the San Mateo County health system for low income people, a pattern that will be monitored in future years of the evaluation.

**Factors in Success.** The factors in the success of the first year of the San Mateo County CHI provide lessons for other jurisdictions that want to develop similar initiatives. In our interviews, we heard about three prominent factors that were key to the first year of successful implementation. First it was critical to have a core group of involved partners from diverse organizations—public and private—dedicated to common goals. We heard repeatedly of the commitment, passion, optimistic attitude, and gifts of in-kind time and resources from the San Mateo County CHI partners.

Second, it was important to learn from other similar projects, and translate their experience into local circumstances. San Mateo County particularly benefited from the examples of Santa Clara and San Francisco counties. These counties provide models for design and development that San Mateo County CHI partners closely observed as they proceeded with key decisions.

Finally, and perhaps most importantly, the San Mateo County CHI succeeded in developing a diverse funding base for the initiative, even in difficult financial times. The broad collaboration across sectors brought in private sources of financing. The CHI also successfully tapped some unique local funding sources (such as the hospital districts and tobacco tax financing) that may or may not be available in other places. Creating such a diverse funding base requires political skills and attention to the concerns and requirements of each funder.

**Future Challenges.** Based on our process analysis, we also identified some particular challenges on which the San Mateo County partners may want to focus attention as they enter the second year of the CHI. First, in order to improve the health status of low income children in the county, it may be necessary to adapt outreach and educational approaches. While “in-reach” has been successful and should be continued, the CHI may not be fully reaching children who are not yet seeking health care. Also, there does not seem to be a strong effort in place to follow up with the parents of children who are enrolled, in order to educate them about the importance of preventive care. Fortunately, there is a firm base upon which to build such outreach and education, although new partners may be useful such as lay community workers (“*promotoras*”).

Our site visit raised questions about the strength of the private provider network, in general, and the availability of dental services specifically. It is important that there be dentists and private physicians actively participating in CHI deliberations, in order to solicit help in CHI efforts. For example, private providers both could identify children in their practices who need health insurance coverage, as well as assure access by continuing to provide care to them once they are enrolled. Thus, further initiatives to involve private providers are critical to expanding access to care, especially for higher income families who may need health insurance coverage but be reluctant to enroll their children in Healthy Kids if their providers do not participate.

Another area for consideration is the complexity of the enrollment and funds transfer processes. Partners are already beginning to fine-tune these processes that were set up for expediency to begin rapid CHI implementation, and there are good reasons for continuing some apparently complex procedures that are working well. Still a thoughtful examination of them, perhaps in comparison to the way that similar processes are handled in neighboring counties, could lead to some efficiency.

Finally, in terms of challenges facing the CHI, external factors will have an important influence on how the CHI proceeds. It goes without saying that one looming issue for the CHI is the future of the Health Plan of San Mateo. In addition, the way that the state addresses its budget issues, both in financing Medi-Cal and Healthy Families, will provide major challenges to the CHI. The partners are fully aware of these issues and are working collectively to both monitor developments and to seek solutions.

**A National Perspective.** The challenges faced by the San Mateo County CHI, and the ways that they are being addressed, can be viewed in the context of other programs to expand children's health insurance coverage nationwide. Results from our evaluations of similar programs should give CHI partners some confidence, first, that they are not unique in facing such challenges, and, second, that their initial efforts to address their challenges are meeting with relative success. The San Mateo County CHI, in one year, has demonstrated that it could rapidly design and implement a health insurance system (Healthy Kids) that provides new and relatively generous coverage to previously-uninsured children. The design of Healthy Kids (both benefits

and cost sharing requirements) is similar to most of the more generous SCHIP programs around the country.

Second, the administrative complexity that is necessary to set up enrollment mechanisms for multiple programs is a challenge that is always daunting, and is not unique to San Mateo County. Indeed, the close working relationship between the three key bureaucracies (Health Services, Human Services, and the HPSM) is not found in many places. Our other evaluations have also found that many public health insurance programs have great difficulty encouraging the participation of private providers, especially dentists.

In conclusion, when viewed from a national perspective, San Mateo's experiment in universal health insurance coverage for children below 400% of the poverty level is pioneering. Indeed, the budget stringency of federal, state, and local governments has prevented most local jurisdictions from being able to consider covering uninsured children. Consequently, the results from San Mateo County's efforts to provide coverage to all children, as well as those of its neighboring counties, will be of great interest to federal, state, and local government policy makers around the county.

## **ADDENDUM: PLANS FOR THE SECOND YEAR OF THE EVALUATION**

We will continue the evaluation activities of the first year and add several new activities in the second year. The following brief descriptions provide the Oversight Committee and others with an overview of those activities and the resulting analyses that will be included in the second annual report.

**Process Analysis:** The data sources for the process analysis are: (1) results from the annual site visits to the county to interview key partners, and (2) parent focus groups. Such a site visit occurred in year one of the evaluation (October, 2003) and another one, of similar scope, is planned for year two, some time in the summer to fall of 2004. The information learned in this site visit will allow the evaluation team to continue tracking the history of implementation, and the lessons learned from that process, as described in this annual report.

In addition to the site visit, the Aguirre group will conduct three focus groups with parents during the second evaluation year. The first group, a pilot focus group to test the protocol and procedures, is planned for December 2004, and two more groups—one of parents of recently enrolled Healthy Kids and one of parents of Healthy Kids who have been enrolled for at least a year—are planned for January 2005. We hope to learn from these families about their experience before they were enrolled, how they learned of the program, their experience with the enrollment process, their satisfaction with Healthy Kids, and any barriers they face to getting services. While these issues are also addressed in the client survey (described below), the focus groups will provide a more in-depth, qualitative assessment of these issues from the parents' points of view. Probably all three of the groups will be held in Spanish.

**Descriptive Program Analysis.** The descriptive program analysis is based on the analysis of data from three data sources: a client survey, aggregate data from the Health Plan of San Mateo, and aggregate data from the Hospital Consortium.

The Client Survey is an important new data source that will be available in evaluation year two. We developed the survey instrument based on two similar questionnaires that have previously been field tested for reliability and validity: the Santa Clara Healthy Kids Survey and the National State Children's Health Insurance Program (SCHIP) Survey. The survey is being conducted by Mathematica Policy Research.

The survey gathers data on six key topics:

- Background characteristics
- Enrollment and retention in the program
- Health insurance coverage
- Access and satisfaction with care
- Utilization of services
- Health status

We plan to survey 400 families who are currently enrolled in Healthy Kids. In late January we conducted a pilot test of the survey and contact procedures with a dozen families enrolled in Healthy Kids. The purpose of the pilot test was to assess question wording and respondent comprehension, question flow, survey length, sample contact rates, and potential reaction to the survey including receipt of the endorsement letter. The instrument tested very well, with only minor modifications. Respondent cooperation to the survey was very high, although over one-third families could not be immediately contacted the phone number on file was either no longer working or a wrong number. (Such families will require additional special locating efforts.)

Data collection for the survey began during the last week of February 2004. Prior to the evaluation team's calls to the families selected to participate, the Health Plan of San Mateo mailed endorsement letters to all sampled families. To date we have completed nearly 300 survey interviews. Cooperation with the survey by families we have been able to contact remains very high. However, 50 to 70 percent of the remaining non-completed cases have incorrect or non-working phone numbers that will require special locating procedures. We anticipate we will finish interviewing families in early May 2004.

As with year one of the evaluation, we also plan to obtain aggregate data from the Health Plan of San Mateo and the Hospital Consortium, and analyze the data for the second annual report. The health plan data will show how the patterns in demographic characteristics, health service use, and cost are changing over time for Healthy Kids, Healthy Families, and Medi-Cal

children. The Hospital Consortium data will show whether and how hospital patterns in uncompensated care are changing as a result of the Children's Health Initiative.

**Provider Analysis.** The provider analysis is being led by Dana Hughes of UCSF. We are currently consulting with the Evaluation Subcommittee about plans for this analysis, since the health plan is no longer planning to conduct a provider survey in the near future. The original plan was to hold two focus groups with providers in the second year of the evaluation (in the fall 2004), the first with non-contracting providers (physicians and dentists) and the second with contracting dentists. We did not plan to meet with participating doctors but would instead draw from the health plan's provider survey (to which we were to add questions). However, because the health plan's survey is presently on hold, we propose that we include contracting physicians in the second focus group.

We also planned to conduct joint focus groups with physicians and dentists. However, because these two professions differ in so many ways, it now seems that it would be best to separate them. That is, we would hold two focus groups of physicians and two of dentists.

Once these design questions are resolved, planning for the focus groups will begin. We anticipate that recruitment of non-contracting providers may be a challenge, so we want to begin shortly to explore with the local Medical and Dental Societies how they suggest we identify the providers and invite their participation. We will develop the interview protocols and seek Human Subjects Committee approval from UCSF. The interview protocols will be built around our research questions. Our chief research question with respect to the non-contracting providers is to learn more about why they do not participate. Secondly, we would like to learn what they know about Healthy Kids and the CHI in general. For the contracting providers, we want to learn about why they participate, their perceptions of how the CHI is working, and what could be improved. We also want to learn if their practices have changed after the Healthy Kids program was implemented, and if there are differences in health status and utilization between Healthy Kids, Healthy Families and Medi-Cal patients.

**Table 1**

**Research Questions for the Evaluation of the San Mateo County CHI**

<b>Research Question</b>	<b>Data Source</b>
Did the level of health insurance coverage change for children in San Mateo County?	Administrative data on enrollment growth, population survey (First 5), parent and employer focus groups, and client survey (waves one and two).
Who is served by the San Mateo County CHI?	Health plan data and client survey (waves one and two).
What services did Healthy Kids enrollees receive as part of the initiative?	Health plan data and client survey (waves one and two).
Did the CHI affect access to care for children who enrolled?	Health plan data, client survey (waves one and two)
Did the CHI affect where services were received?	Health plan data, client survey (waves one and two)
Did the CHI affect the cost of care?	Health plan data, client survey (waves one and two), hospital consortium data.
Did the CHI affect the health status of children enrolled?	Client survey (wave two).
Did the CHI affect school performance or quality of life?	Client survey (wave two).
Were parents satisfied with the new program and services?	Parent focus groups, client survey (waves one and two).
Were providers satisfied with the new program and services?	Provider focus groups
Did public coverage replace private coverage?	Population survey (First 5), parent and employer focus groups, and client survey (waves one and two).
Did the CHI enhance the delivery and stability of the community health care system?	Site visits, provider focus groups, hospital consortium data.
Did the CHI increase community-wide collaboration to address issues of the uninsured?	Site visit interviews.

**Table 2**  
**Proposed Schedule for San Mateo Evaluation**

**Year One**

- Design special questions for population survey
- Site visit (October, 2003)
- Negotiations for plan and hospital consortium data; specify tables, obtain data
- Annual report: includes analysis of site visit information, plan and consortium data
- First wave of client survey (February-April, 2004)

**Year Two**

- Site visit (summer/fall, 2004)
- Focus groups with families and providers
- Obtain plan and consortium data
- Annual report: includes analysis of site visit information, first wave of client survey, parent and provider focus groups, plan data, and hospital consortium data.

**Year Three**

- Site visit
- Second wave of client survey (January, 2006)
- Focus groups of employers
- Obtain plan and consortium data
- Annual report: analysis of site visit information, initial impacts from client survey, employer focus groups, plan data, hospital consortium data

**Year Four**

- Site visit
- Analysis of second wave of population survey
- Another round of focus groups with parents
- Obtain plan and consortium data
- Annual report: analysis of site visit information, final impacts from wave two of the client survey, focus groups, plan and hospital consortium data, insurance and crowd-out results

**Year Five**

- Final site visit
- Obtain plan and consortium data
- Final report (synthesis of findings)

**Table 3**  
**Demographic Characteristics**  
**Ever-Enrolled Children Ages 0-18**  
**Healthy Kids, Healthy Families, and Medi-Cal Enrollees**  
**Health Plan of San Mateo**  
**February–August 2003**

<b>Characteristics</b>	<b>Healthy Kids</b>	<b>Healthy Families</b>	<b>Medi-Cal</b>
Total N	6,025	3,067	28,198
Total %	100.0%	100.0%	100.0%
Age			
0-5	21.5%	23.1%	47.4%
6-12	43.0	49.2	32.2
13-18	35.5	27.7	20.4
Language			
English	15.5%	NA	NA
Spanish	83.4		
Other	1.1		
Level of Poverty			
Below 151%	59.8%	NA	NA
151-250%	11.1		
251-300%	12.0		
301-400%	2.8		
Missing	14.4		
Legal Status			
Documented	7.7%	NA	NA
Undocumented	92.3		

NA: Not Available.

**Table 4**

**Preventive and Non-Preventive Ambulatory Visits  
Continuously-Enrolled Children Ages 0-18  
Healthy Kids, Healthy Families, and Medi-Cal Enrollees  
Health Plan of San Mateo  
February–August 2003**

<b>Type of Visit</b>	<b>Healthy Kids (6 months)</b>	<b>Healthy Families (6 months)</b>	<b>Medi-Cal (6 months)</b>	<b>U.S. Total (Annual)</b>
<b>Total N</b>	914	1,531	17,541	
<b>Preventive Care</b>				
(% With any visit)				
Clinic	12.6%	9.9%	16.9%	
Other doctor	4.4	12.0	11.5	
<b>Other Ambulatory Care</b>				
(% With any visit)				
Clinic	37.1%	29.5%	35.4%	
Other doctor	5.0	21.4	26.0	
<b>% With at least one ambulatory visit of any type</b>	52.1%	53.1%	55.1%	<b>87.3%<sup>1</sup></b>

<sup>1</sup> The percent with a health care visit to an office or clinic within the past 12 months among children under 18 years of age, 2000-2001. Centers for Disease Control and Prevention. National Center for Health Statistics. *Health, United States, 2003 with Chartbook on Trends in Health of Americans*.

Note: Preventive care is identified by the diagnosis or procedure code. Clinics are identified by claim type, and include public and non-profit freestanding and hospital-based clinics. “Other Doctors” are those practicing outside such clinic settings.

**Table 5**  
**Emergency Room Visits and Hospital Stays**  
**Continuously-Enrolled Children Ages 0-18**  
**Healthy Kids, Healthy Families, and Medi-Cal Enrollees**  
**Health Plan of San Mateo**  
**February – August 2003**

	<b>Healthy Kids (6 months)</b>	<b>Healthy Families (6 months)</b>	<b>Medi-Cal (6 months)</b>	<b>U.S. Total (Annual)</b>
<b>Total N</b>	914	1,531	17,541	
<b>Emergency Room Visits</b>				
None	95.1%	91.2%	82.3%	
1	4.3%	6.1%	12.3%	
2+	0.7%	2.7%	5.4%	<b>6.8%</b> <sup>1</sup>
<b>Hospital Stays</b>				
None	99.6%	99.4%	98.6%	<b>95.7%</b> <sup>2</sup>
1	0.4%	0.6%	1.3%	
2+	0.0%	0.0%	0.1%	

<sup>1</sup> Percent of children under aged 18 with 2 or more emergency room visits in the past 12 months, 2001.

<sup>2</sup> Rate of discharge from non-federal short stay hospitals, 2001. Excludes newborns.

Sources for both U.S. estimates: Centers for Disease Control and Prevention. National Center for Health Statistics. *Health, United States, 2003 with Chartbook on Trends in Health of Americans.*

**Table 6**  
**Average Cost per Eligible Child**  
**Continuously-Enrolled Children Ages 0-18**  
**Healthy Kids, Healthy Families, and Medi-Cal Enrollees**  
**Health Plan of San Mateo**  
**February-August 2003**

<b>Type of Service</b>	<b>Healthy Kids (6 months)</b>	<b>Healthy Families (6 months)</b>	<b>Medi-Cal (6 months)</b>	<b>U.S. Total (Annual)</b>
Outpatient and Clinic	\$55.91	\$42.60	\$63.98	
Other Physician	\$9.17	\$32.96	\$29.80	
ER	\$6.54	\$14.82	\$32.59	
Hospital	\$22.97	\$28.10	\$84.63	
Vision	\$4.11	--	\$2.24	
Hearing	\$1.83	\$1.60	\$1.08	
Dental	\$110.14	--	--	
Prescriptions	\$7.99	\$22.88	\$55.76	
Other	\$5.27	\$3.07	\$62.35	
<b>TOTAL</b>	<b>\$223.93</b>	<b>\$146.01</b>	<b>\$332.43</b>	<b>\$1,022.00<sup>1</sup></b>

<sup>1</sup>Estimate based on mean annual expenditures for health care and prescribed medicine 1999 per person aged 6-17.  
Source: Centers for Disease Control and Prevention. National Center for Health Statistics. *Health, United States, 2003 with Chartbook on Trends in Health of Americans.*

**Table 7**  
**Emergency Room Visits**  
**Children 0-18 by Hospital and Health Insurance Coverage**  
**San Mateo County**  
**Fiscal Years 2001-2003**

	<b>San Mateo Medical Center</b>	<b>Seton Medical Center<sup>1</sup></b>	<b>Total</b>
<b>Healthy Kids</b>			
2001	-	-	-
2002	-	-	-
2003	56	-	56
<b>Healthy Families</b>			
2001	54	-	54
2002	90	-	90
2003	182	-	182
<b>Medi-Cal</b>			
2001	1,059	1,259	2,318
2002	1,615	1,251	2,866
2003	2,249	1,956	4,205
<b>Uninsured</b>			
2001	1,383	677	2,060
2002	1,289	560	1,849
2003	1,194	515	1,709

<sup>1</sup>. For Seton Medical Center, Healthy Kids and Healthy Families data are grouped with Medi-Cal.

Note: The San Mateo Medical Center and Seton Medical Center fiscal years are from July to June.

**Table 8**  
**Hospital Stays**  
**Children Aged 0-18 by Hospital and Health Insurance Coverage**  
**San Mateo County**  
**Fiscal Years 2001-2003**

	<b>Mills Peninsula Hospital<sup>1</sup></b>	<b>San Mateo Medical Center</b>	<b>Seton Medical Center</b>	<b>Total</b>
<b>Healthy Kids</b>				
2001	-	-	-	-
2002	-	-	-	-
2003	0	0	0	0
<b>Healthy Families</b>				
2001	0	0	0	0
2002	0	2	0	2
2003	0	4	0	4
<b>Medi-Cal</b>				
2001	511	79	304	894
2002	627	91	248	966
2003	649	73	138	860
<b>Uninsured</b>				
2001	43	20	12	75
2002	34	18	11	63
2003	43	12	6	61

<sup>1</sup> For Mills-Peninsula Hospital and Seton Medical Center, Healthy Kids and Healthy Families data are grouped with Medi-Cal.

Note: The Mills-Peninsula fiscal year is from January to December. The San Mateo Medical Center and Seton Medical Center fiscal years are from July to June.

**Table 9**  
**Revenues and Uncompensated Care**  
**Children Aged 0-18**  
**San Mateo Medical Center**  
**Fiscal Years 2001 to 2003**

<b>Fiscal Year</b>	<b>Revenues</b>	<b>Uncompensated Care</b>
<b>2001</b>	\$386,632	\$1,404,553
<b>2002</b>	\$533,770	\$1,845,235
<b>2003</b>	\$621,765	\$1,396,548

Note: The San Mateo Medical Center fiscal year is from July to June.

## **Glossary of Acronyms**

**BA** - Benefits Analyst

**CAA** - Certified Application Assistor

**CAP** - Community Access Program

**CBO** - Community Based Organization

**CHA** - Community Health Advocate

**CHDP** - Child Health and Disability Prevention

**CHI** - Children's Health Initiative

**COHS** - County Organized Health System

**HF** – Healthy Families

**HK** – Healthy Kids

**HPSM** - Health Plan of San Mateo

**MC** – Medi-Cal

**MOU** – Memorandum of Understanding

**MRMIB** - Managed Risk Medical Insurance Board

**PCF** - Peninsula Community Foundation

**PCP** - Primary Care Provider

**RFI** - Request for Information

**SCHIP** - State Children's Health Insurance Program