



Obstructed Entry: CHDP Fails as Gateway To Affordable Health Care

The Program

The Children's Health and Disability Prevention (CHDP) program pays health care providers for completing health screens and immunizations of low-income children who are uninsured.

LAO Findings

Since CHDP's establishment in 1973, California's health care delivery system has undergone significant change. Now the Medi-Cal and Healthy Families Programs offer more comprehensive health care alternatives for CHDP clients.

This evolution in the health care environment resulted in the state establishing a new role for CHDP—as a “gateway” facilitating children's enrollment in the Healthy Families Program. Our overall assessment is that the gateway was never fully established. This has resulted in missed opportunities to provide comprehensive health coverage for low-income children, as well as a missed opportunity to use available federal funds to help support the cost of providing the care.

LAO Recommendations

We propose the establishment of a new integrated system of care that establishes CHDP as an effective gateway to enrollment in the Medi-Cal and Healthy Families Programs. Specifically, we recommend establishing new requirements for providers to encourage families to enroll their children in the Medi-Cal or Healthy Families Programs. In addition, we recommend changing the income eligibility level for CHDP to correspond to that of the Healthy Families Program, in order to maximize CHDP's capacity as a gateway to enrollment.

We also propose that counties provide more assistance to families in applying for such health coverage and recommend simplification of the application process. Finally, we recommend (1) a study to improve CHDP's computerized data system to reduce the risk of duplicate payments for health services and facilitate tracking of enrollment and (2) a centralized Medi-Cal application processing system to facilitate application tracking.

While these recommendations will result in some costs, we believe that shifting services to more comprehensive programs that have federal funding should generate net savings to the General Fund in the long run and allow more children to receive healthcare services.

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January 30, 2001



BACKGROUND

Eligibility. The state Child Health and Disability Prevention (CHDP) program was established by Chapter 1069, Statutes of 1973 (AB 2068, Brown), to provide preventive health, vision, and dental screens to children and adolescents in low-income families who do not qualify for Medi-Cal. It is modeled after the federal Medicaid benefit called Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The CHDP program reimburses public and private providers for completing health screens and immunizations. An estimated 1.8 million screens will be provided in fiscal year 2000-01.

Administration. The program is jointly administered by the state Department of Health Services (DHS) and county health departments. The DHS provides statewide oversight of the program, including making payments to providers. The county health departments develop local plans to recruit CHDP providers, ensure CHDP provider outreach and education, and handle client referrals and follow-up.

Funding. When the CHDP program was first established, it was solely funded from the state General Fund. In 1989, following the passage of the Tobacco Tax and Health Protection Act (also known as Proposition 99), part of the funds from the new cigarette tax were appropriated to expand the program to include more age groups and clients with higher incomes. As a condition of receiving Proposition 99 funding for indigent

health care, counties were also required to provide treatment services for medical conditions detected as part of a CHDP health examination. Some counties have had to supplement their Proposition 99 funds to pay for these follow-up services. (For more information on the follow-up treatment aspect of the program, please see *Child Health and Disability Prevention Program: Department Not Enforcing Treatment Requirement, Analysis of the 1997-98 Budget Bill*—page C-64.)

In response to fiscal pressure caused by declines in cigarette tax revenue, the *2000-01 Budget Act* replaced CHDP's Proposition 99 appropriation with money from the General Fund, thus, freeing up \$56 million of for use in other programs.

The Governor's proposed 2001-02 budget projects total CHDP expenditures of about \$125 million, with about \$49 million in support from the General Fund, \$65 million from the newly established Tobacco Settlement Fund, and the remaining \$11 million from federal and special funds. The revenues in the Tobacco Settlement Fund are the result of the 1998 settlement of a lawsuit brought by several states against the major tobacco companies. The budget proposes to shift funding for the portion of CHDP that was previously supported by Proposition 99 funds from the General Fund to the Tobacco Settlement Fund.

Figure 1 summarizes the key eligibility, administrative, and funding provisions of the CHDP Program.

THE CHANGING LANDSCAPE OF HEALTH CARE

The CHDP's Role: Then and Now

Program Initially Filled Gap in Coverage.

When the CHDP was established in 1973, the availability of subsidized health care for children was very limited. Eligibility for Medi-Cal—then the state's only comprehensive health coverage program—was restricted to children whose families were either on welfare, or had the same income characteristics as welfare families. Children in low-income, two-parent working families generally did not qualify for the Medi-Cal Program. Thus, the CHDP program, though limited to coverage of preventive health screens and medically necessary follow-up treatment, filled a fundamental gap in the availability of care for low-income children.

Today the landscape of affordable health care is very different. The link between Medi-Cal and welfare has been severed, thereby expanding

access to infants and children in families with higher incomes. The Healthy Families Program has been implemented and now provides comprehensive health insurance coverage similar to Medi-Cal for children in families with income up to 250 percent of the federal poverty level (FPL). In addition, policy changes have been made to Medi-Cal and Healthy Families, such as application streamlining and one-year continuous eligibility, to remove access barriers and prevent unnecessary breaks in coverage.

Current Overlap in Programs. As a result of the income eligibility expansions in Medi-Cal and Healthy Families, there is now overlapping income eligibility standards for these three programs. Children using CHDP are either (1) eligible to enroll for full Medi-Cal benefits,

(2) eligible to enroll in Healthy Families, or (3) undocumented immigrants, and therefore ineligible for either of the other two programs. (Undocumented immigrants qualify for no-cost Medi-Cal, but only for emergency care, including labor and delivery services.) Figure 2 (see page 4) summarizes the eligibility criteria for CHDP, as well as those for the Healthy Families and Medi-Cal Programs. The figure illus-

Figure 1

Key Provisions of CHDP

- **Eligibility.** The CHDP program pays for periodic health screens of children and youth up to age 19, who are uninsured and whose family income is at or below 200 percent of the federal poverty level. A child qualifies for this service when his or her family submits a one-page eligibility form at the time of the doctor's visit that attests to these eligibility criteria.
- **Administration.** The state Department of Health Services sets regulations and processes and pays the medical claims of participating health care providers. The daily management of the program occurs at the local level through county health departments and CHDP providers.
- **Funding.** Ninety percent of CHDP's program costs are funded from the General Fund. An assortment of other fund sources support the rest of the \$111 million budget in 2000-01.



Figure 2

Income Eligibility Criteria for CHDP, Medi-Cal, and Healthy Families

Age	Family Income (As Percent of Federal Poverty Level)
CHDP	
• 0-18 years of age	• At or below 200 percent
Medi-Cal (Poverty Group)^a	
• 0-11 months of age	• At or below 200 percent
• 1-5 years of age	• At or below 133 percent
• 6-18 years of age	• At or below 100 percent
Healthy Families	
• 0-11 months of age	• Between 200 percent and 250 percent
• 1-5 years of age	• Between 133 percent and 250 percent
• 6-18 years of age	• Between 100 percent and 250 percent

^a Children who meet eligibility criteria for enrollment in no-cost Medi-Cal.

Medi-Cal and Healthy Families provide a full range of medical benefits, as well as dental and vision care. Figure 3 compares the benefits for these three programs.

Second, Medi-Cal and Healthy Families provide a “medical home” by allowing the families to choose a health plan and regular doctor, as well as around-the-clock access to care. By contrast, in some counties, CHDP services are only

trates the overlap in income eligibility that exists among the three programs.

Because of limitations in CHDP’s data collection, DHS does not know what percentage of its CHDP clients are eligible for Medi-Cal, Healthy Families, or undocumented immigrants, and therefore are ineligible to enroll in Healthy Families or full-scope Medi-Cal. We do know, however, that all CHDP clients fall into one of these categories.

Advantages of Healthy Families and Medi-Cal

There are several reasons why it is advantageous for CHDP clients who qualify for Medi-Cal or Healthy Families to be enrolled in these programs. First, Medi-Cal and Healthy Families offer free or low-cost *comprehensive* health coverage. Although all three programs provide coverage for preventive health screens and immunizations,

available for a few hours on certain days of the week. Anecdotal evidence also indicates that CHDP clients needing follow-up care often wait months to be treated. This is especially the case for follow-up dental care.

Third, the federal government shares in the cost of the Medi-Cal and Healthy Families Programs, contributing approximately 50 percent and 67 percent, respectively. As mentioned previously, the state CHDP program is funded almost entirely by state funds. Therefore, shifting children from the CHDP program to the other programs would produce immediate state savings. There would also be savings for counties which would otherwise have to spend county General Fund monies to supplement their Proposition 99 funds for CHDP follow-up treatment.

Figure 3

CHDP Benefits Not as Comprehensive as Medi-Cal and Healthy Families

Program	Primary Care	Inpatient/Outpatient Treatment	Dental Care	Drug Coverage
Medi-Cal	Comprehensive	Comprehensive	Comprehensive	Comprehensive
Healthy Families	Comprehensive	Comprehensive	Comprehensive	Comprehensive
CHDP	Limited to health screens	Limited to "medically necessary" treatment Subject to the availability of funds	Limited to "medically necessary" treatment Does not include preventive dental services	Limited to "medically necessary" treatment

Given all of these advantages of Medi-Cal and Healthy Families over the CHDP program, we believe the gateway concept is a sound one. During the 1999-00 legislative session, the Legislature and Governor committed to enrolling 80 percent of the eligible Healthy Families population. Based on our review of participation in other public programs—such as Medi-Cal—we believe that the state will find it difficult to achieve and

maintain this goal of 80 percent participation in Healthy Families unless multiple strategies are implemented. Our analysis suggests that an effective CHDP gateway could move the state closer to this goal. This is because CHDP clients represent the vast majority of children who are eligible under Healthy Families and Medi-Cal. In fact, the 2000-01 state budget assumes that many of them will soon be enrolled in Healthy Families coverage.

THE CHDP IS NOT AN EFFECTIVE GATEWAY

After examining the available data and meeting with DHS and local CHDP program representatives, we have concluded that CHDP is not functioning as an effective gateway. Our conclusion is based on data indicating a low level of enrollment of CHDP children in Healthy Families, as well as our findings related to the lack of state direction

and coordination of local level efforts. These issues are discussed in greater detail below.

Few Children Enter Healthy Families Through CHDP Gateway

As a gateway program, CHDP services provided to children who enrolled in Healthy Families within a 90-day period are to be reimbursed by



the Healthy Families Program. This retroactive payment allows the state to maximize federal funds and save state General Fund monies for the CHDP program. When the gateway concept was adopted, DHS assumed that 50 percent of Healthy Families' enrollees would enter the program shortly after using CHDP services. However, CHDP clients are not enrolling in Healthy Families at the anticipated rate.

The best available indicator of the number of children enrolling in Healthy Families through CHDP is the level of reimbursement to CHDP for services provided to children who ultimately enroll in Healthy Families. In 1999-00, the most recent year for which data are available, only 4.5 percent of the new enrollees in Healthy Families had reimbursed CHDP claims. This represents a slight increase over 1998-99, when claims were reimbursed for only 3.4 percent of new Healthy Families' enrollees. Due to a recent change in the retroactive claiming period—from 30 days to 90 days—we estimate that CHDP will be reimbursed for 9.6 percent of Healthy Families' enrollees in 2000-01. However, this is still a relatively small number of CHDP clients. Figure 4 shows initial expectations for CHDP reimbursements compared to actual reimbursements.

These figures probably underestimate somewhat the number of CHDP children enrolling in the Healthy Families Program. This is because they only reflect the number of children who were admitted into the program within the retroactive claiming period. However, the Managed Risk Medical Insurance Board (MRMIB)—the state department that administers the Healthy Families Program—has indicated that the 90 day retroactive claim period would capture approximately 90 percent of Healthy Families' new enrollees.

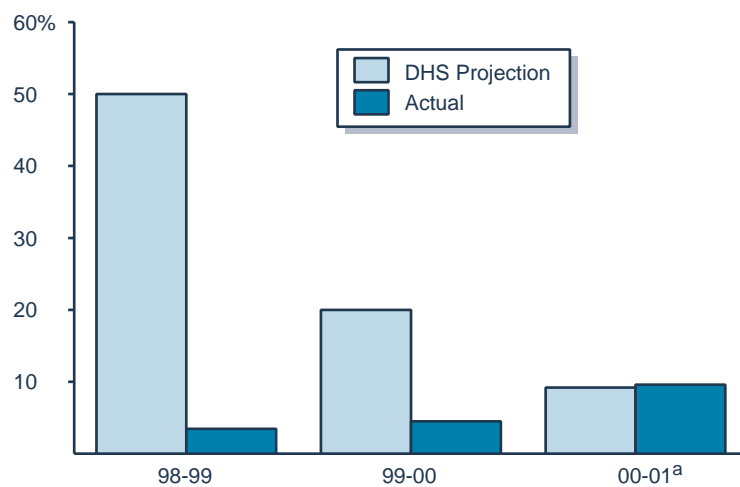
The DHS Has Not Developed a System of Coordination

Given data showing that large numbers of Healthy Families clients are not entering the

Figure 4

Few CHDP Clients Enrolling in Healthy Families

Reimbursed CHDP Claims as a Percentage of Healthy Families' New Enrollees



^a 2000-01 is an LAO estimate based on first quarter trends.

program from CHDP, we examined the state and local efforts to incorporate CHDP into the Healthy Families Program.

State Efforts. On the plus side, we found that DHS has distributed policy letters to CHDP health care providers encouraging them to promote enrollment in the Healthy Families Program. The DHS staff have also verbally encouraged promotion of enrollment at statewide meetings with local program officials.

However, DHS has not incorporated Healthy Families enrollment activities into CHDP program procedures. For example, it has not required CHDP providers to facilitate enrollment in Healthy Families. Nor, has DHS given local CHDP programs additional resources to take on new activities that would be necessary in order to effectively integrate the two programs. Additionally, DHS and MRMIB have not established any standard operating procedures for the provision of Healthy Families information or materials to local CHDP programs. Overall, the absence of a statewide system to enroll CHDP clients in the Healthy Families and Medi-Cal Programs results in a lack of coordination at the local level.

Local Efforts. Our review of local CHDP office activities found that they are attempting to incorporate the promotion of Healthy Families enrollment into their activities, but this is being done with a minimal investment of resources in most counties. The most common form of outreach appears to be the inclusion of Healthy Families and Medi-Cal information in the letters that offices

send out to CHDP clients who are in need of follow-up treatment. Los Angeles, the county serving the greatest number of CHDP clients, takes such an approach. In addition, some county health departments have received Medi-Cal/Healthy Families outreach contracts—funds awarded to community-based organizations, school districts, and local governments—to provide outreach and education about Healthy Families and Medi-Cal for children. Unfortunately, we found that CHDP staff are not always incorporated into these outreach activities.

In some counties, however, local programs have included additional interventions, either as one-time efforts or in their routine interactions with clients. In Marin County, for example, the local CHDP office collaborated for four months with its largest CHDP provider—a community clinic—to identify uninsured CHDP clients who were due for clinic appointments and to assist them in enrolling in Healthy Families or Medi-Cal. In Sonoma County, certified application assistants across the county work as a single team, using tracking forms that are entered into a database and used for follow-up and to measure outcomes. Other local CHDP offices that we contacted have incorporated a Healthy Families component into their training of CHDP providers. Additionally, in some counties when local CHDP staff conduct site visits every other year at providers' offices for quality assurance purposes, they use this opportunity to speak with doctors about the Healthy Families Program.



While these efforts by local CHDP offices to educate CHDP clients and providers about Healthy Families and Medi-Cal may be helping to generate more knowledge about the two health programs, their true effect on program enrollment is not known. It is clear, however, that the retroac-

tive reimbursement data show disappointing enrollment trends overall. Moreover, the great variation in local efforts strongly suggests that the current approach to facilitating Healthy Families and Medi-Cal enrollment via CHDP falls short of maximizing CHDP's potential as a gateway program.

BUILDING A GATEWAY THAT WORKS

We recommend several policy and technological changes that we believe would make CHDP an effective gateway to comprehensive health coverage for additional low-income children. Figure 5 summarizes our major recommendations.

providers to encourage families to apply for Medi-Cal or Healthy Families. We believe such legislation could convert the CHDP Program into a true point of entry for the Healthy Families and Medi-Cal Programs.

What Would a Model Gateway Program Look Like?

The CHDP as an Interim

Form of Care. In order to transform CHDP into an effective gateway to Healthy Families and Medi-Cal, CHDP should be used as an interim provider of preventive health care while CHDP clients apply for the appropriate health insurance program. Given the fact that CHDP now serves many children who are eligible for Medi-Cal and Healthy Families, we recommend the enactment of legislation establishing new requirements for health care

How Would This Be Accomplished? Here is how a modified CHDP program could work.

Figure 5

CHDP as a Model Gateway LAO Recommendations

- **Health Care Providers.** Enact legislation establishing new requirements for health care providers to encourage families to apply for Healthy Families or Medi-Cal.
- **Local CHDP Staff.** Encourage counties to use local CHDP staff to assist clients in applying for Healthy Families and Medi-Cal, and streamline the application process with a new on-line computer program.
- **Centralized Determination System.** Reconsider legislation to process all Medi-Cal family and child applications through a centralized and simplified, state-level eligibility determination system.
- **Information System Link.** Adopt supplemental report language directing DHS to analyze the feasibility of linking the CHDP information system with the Medi-Cal and Healthy Families information systems.
- **Family Income Level.** Make additional children eligible for CHDP services by increasing the maximum allowable family income to 250 percent of the federal poverty level once the gateway model has been implemented.

In order for a provider to receive a reimbursement from CHDP for a health screen, the client for whom reimbursement is sought must have applied for Medi-Cal or Healthy Families. The provider would record on each CHDP claim the proof that the client's family has applied for Medi-Cal or for Healthy Families coverage. The family would be assisted in completing the application.

Proof of Application. Under our proposal, CHDP's current medical and payment claim, called a PM160, would be modified to provide a place for a provider to record a unique tracking number for each CHDP client application. Depending upon the circumstances, this number could be the unique identification number included on each joint mail-in Medi-Cal/Healthy Families application, or the unique number now used to identify each Medi-Cal application submitted to a county welfare office.

When a family first called to make a CHDP appointment for their child, the provider would direct the family to apply for coverage from Healthy Families or Medi-Cal. The family would also be directed to bring to that appointment either a copy of their application or a letter from the welfare office documenting that they had applied for benefits. The required documents would provide the unique identifier needed by a provider to obtain payment for the CHDP services for that family.

Needed Safety Net for Some. While the majority of CHDP clients are eligible for either full-scope Medi-Cal or Healthy Families, some CHDP

clients—in particular, undocumented immigrants—are not, under federal and state law. For these children, CHDP remains a “safety net” program. Under our proposal, a letter from MRMIB or the county welfare office to the child's family denying enrollment to Healthy Families due to insufficient immigration documentation could be presented to the provider as verification that the child is eligible for additional CHDP screens.

Keeping CHDP Services Accessible. In theory, linking payments for CHDP screens to requirements that families apply for Medi-Cal and Healthy Families could prompt some families not to utilize CHDP. Some families might believe that completing the application is too much effort. Others, namely immigrant families—both documented and undocumented—might fear that applying for a government-sponsored program will jeopardize their residence in the United States or will deem them a liability to their U.S. sponsor. These fears persist, despite written clarification from the Immigration and Naturalization Service (INS) in May 2000 that the federal government will not screen applications of persons enrolling in Medi-Cal or Healthy Families to determine their immigration status.

In order to ensure continued access to CHDP health care services, we recommend that several steps be taken. First, we recommend that local CHDP offices or the Healthy Families community outreach contractor ensure that each provider has an up-to-date list of certified application assistants available in the area to assist each family. The larger CHDP providers, such as community



clinics, might find it beneficial to have certified application assistants on site to expedite application completion and submission. (We note that many clinics already provide this assistance.) Community-based organizations that provide certified application assistance could further collaborate with providers to station application assistants in providers' offices.

We further recommend the enactment of legislation directing DHS and MRMIB to implement a coordinated education campaign involving local CHDP staff and certified application assistants. The purpose of the education campaign would be to assure CHDP families that submitting their applications to Medi-Cal and Healthy Families will not result in any action against them by the INS.

We believe that such education and assistance efforts could help to ensure continued access to CHDP services as the state makes efforts to provide more comprehensive health coverage for many additional low-income children.

Building Better Linkages to CHDP

We believe that the state should consider further changes in state policy and technology that would make CHDP an even more effective gateway program and make implementation of the program changes we have proposed less burdensome for families and providers.

Single Point of Entry Needed for All Applications. Currently, there are two processes in place to determine eligibility for Medi-Cal. Under one method called the "single point of entry," the joint

Medi-Cal/Healthy Families application is processed by Electronic Data Systems (EDS) under contract with the state. The EDS, as the fiscal intermediary for the Medi-Cal and Healthy Families Programs, and is also responsible for making payments to providers. Under the other method, applications are processed by eligibility workers in the county welfare offices.

The *2000-01 Budget Bill* passed by the Legislature provided funding to allow all applications to be processed through a single point of entry. However, the Governor vetoed that appropriation. We recommend that the Legislature and Governor reconsider establishing a single point of entry for all applications. This approach would facilitate the implementation of changes we have recommended by (1) enhancing state oversight of enrollment in Healthy Families and Med-Cal and (2) creating a centralized database with which to compare CHDP claims.

Improvements Needed in CHDP Information System. The existing CHDP computer information system is not compatible with the Medi-Cal and Healthy Families information systems. The systems do not share common identifiers, such as a client names, social security numbers or other account numbers that permit records of CHDP clients to be linked to Medi-Cal or Healthy Families participants. This is because CHDP records track claims while the Medi-Cal and Healthy Families systems track individual clients.

These differences limit the efficiency of CHDP as a gateway program. For example, the absence of a common identifier limits the state's ability to

maximize federal funding and save General Fund monies by retroactively reimbursing CHDP when children enroll in Healthy Families. According to DHS, they are able to match clients for purposes of retroactive reimbursement only 70 percent to 80 percent of the time.

Moreover, since the state has no way of knowing if a child is enrolled in both Healthy Families and CHDP, the state is at risk of making duplicate payments for the same services. Under the current system, a child who is enrolled in Healthy Families could be seen by a CHDP provider. If the CHDP provider has no knowledge of the child's Healthy Families status, the provider could submit a claim and be reimbursed for those services under the CHDP program.

The extent of such double billing and its cost to the state are unknown. There is evidence, however, that such double billing is occurring. We compared our estimates of the number of uninsured children with family incomes below 200 percent of the FPL (the group eligible for CHDP) against DHS's estimates of children who utilize CHDP. The comparison shows that there are more children using CHDP than there are eligible uninsured children. This strongly suggests that children with health coverage (predominantly Healthy Families and Medi-Cal) are in fact, utilizing CHDP services.

Improving the CHDP Data System. If the CHDP program is to become an effective gateway to enrollment in the Healthy Families and Medi-Cal Programs, the state's information system must

be able to distinguish CHDP clients from Healthy Families and Medi-Cal clients for client-tracking purposes—both to ensure the accuracy of payments and to measure enrollment outcomes. Therefore, we recommend that DHS explore ways to improve its data system.

Specifically, we recommend the adoption of supplemental report language to the *2001-02 Budget Act* directing DHS to (1) analyze the limitations of the current CHDP data system in regard to its capacity to accurately compare client data among the CHDP, Medi-Cal, and Healthy Families Programs; (2) explore the feasibility of linking CHDP client data with Medi-Cal and Healthy Families Program data in order to accurately audit medical claims and track individuals across programs; and (3) examine technological alternatives for linking these data. These actions would prepare DHS for the procurement of an improved CHDP information system.

Costs of an Improved Information System. The cost of improving CHDP's information system is unknown at this time. The cost of these improvements could be lower than they would be otherwise if they could be "piggybacked" on to the new information system being developed by the department. The state is currently developing a new information system to link two DHS programs—California Children's Services and the Genetically Handicapped Persons Program—with the Medi-Cal and Healthy Families client and claims databases. Once linked, the new system will be better able to identify and serve clients, maximize receipt of federal funds, and reduce the



cost of manual data collection. Similar improvements could accrue to the CHDP system at less cost if it were included in the new information system.

Streamlining the Application Process. Requiring clients to present documentation that they had applied for Medi-Cal or Health Families coverage could occasionally deter participation in the CHDP program. A family might forget to bring its proof of application and therefore, delay the CHDP screen of a child. Some doctors might resist adding another clerical step to their provision of medical treatment or fear that they might not get paid for providing a screen.

We recommend that such concerns be addressed by implementing an on-line computer program currently under development by a private, nonprofit foundation in cooperation with DHS and MRMIB. This web-based program, called “Health-e-App,” would enable clients and application assistants to apply for children’s enrollment in Healthy Families and Medi-Cal on-line in as little as 20 minutes. The program would maintain a database of all “e-applications,” including whether an application for an individual has been entered and the status of an application in the eligibility determination process.

If DHS expanded the use of Health-e-App to include the Medi-Cal family application process, and if CHDP providers were authorized to query the status of CHDP clients’ applications, families would not need to present proof of application, and providers would need only to check the database for proof of application.

For these reasons, we recommend the adoption of supplemental report language to the *2001-02 Budget Act* directing DHS to investigate (1) expanding the purpose of the Health-e-App program to include electronic applications for Medi-Cal family applications, and (2) strategies to share information electronically among CHDP providers, CHDP clients, and EDS regarding the status of clients’ applications, including the use of the Health-e-App.

Widening the Gateway

Aligning Income Eligibility. Once CHDP has become a true gateway program for comprehensive health coverage, we recommend that the Legislature enact legislation to align income eligibility in CHDP and Healthy Families. Under current program requirements, children are eligible for CHDP services if their family income is no greater than 200 percent of the FPL. At the time that CHDP was proposed as a gateway program, Healthy Families’ income eligibility was also limited to 200 percent of the FPL.

Policymakers have generally found that keeping income eligibility standards the same across similar programs facilitates a “seamless delivery system” by minimizing exclusion from eligibility and simplifying the application process. Given the prior decision of the Legislature to increase Healthy Families’ income eligibility to 250 percent of the FPL, it should eventually consider increasing CHDP’s income eligibility to the same level. By aligning eligibility standards, CHDP could encourage enrollment in Healthy Families for all children who are eligible for Healthy Families, not just for

those whose family income is at or below 200 percent of the FPL.

Expanding income eligibility for CHDP would result in an increase in the program's caseload of one-time clients. However, most children who would become eligible for CHDP under this expansion would also be eligible for enrollment in

the Healthy Families Program. Even their single CHDP screen, then, would be retroactively reimbursed by the Healthy Families Program. Therefore, we recommend that the Legislature enact legislation increasing the income eligibility standard for CHDP to the same level as the Healthy Families Program after the gateway model has been fully implemented.

LOCAL STAFFING CONSIDERATIONS

Impact on Current Staffing Functions. Transforming CHDP into an effective gateway to Healthy Families and Medi-Cal could affect local staffing responsibilities for the CHDP program. If the gateway model is fully implemented, local CHDP offices would likely experience a decrease in the period of time CHDP clients use CHDP services (staying on the CHDP caseload essentially only while applications for other health coverage were pending). Additionally, the CHDP caseload would probably decrease over time as the number of repeat clients were reduced. As a consequence, CHDP staff would eventually have a lighter workload, with fewer clients to track for follow-up treatment.

New Staffing Functions. While local staffing levels could be reduced over time, once the effect of the gateway system is realized, in the interim these staff could shift from managing follow-up cases to assisting CHDP clients in applying for health coverage.

In addition to serving as application assistants, as some local CHDP staff have already opted to

do, local CHDP staff could work with families to resolve any issues that arise after a family has applied for health coverage. For example, the local CHDP staff could assist families after they are denied enrollment in Healthy Families or have not heard back from the county welfare office regarding their eligibility for Medi-Cal. Local CHDP staff could provide valuable help as "patient advocates" of a gateway CHDP program successfully focused on enrolling children in health coverage.

Therefore, we recommend that the Legislature direct DHS to encourage counties to use their local CHDP programs as resources for assisting families in applying for health coverage, by (1) keeping CHDP providers' offices equipped with up-to-date lists of certified application assistants in the local area, (2) collaborating with community-based organizations that provide certified application assistance to station assistants at providers' locations during scheduled CHDP visits, and (3) coordinating with their local health departments, when outreach contracts are awarded, to ensure that prospective CHDP clients' access to application assistance is maximized.



CONCLUSION

The CHDP program was established at a time when low-income children had few options for affordable health care. Expansions in the Medi-Cal Program and the enactment of the Healthy Families Program have created an opportunity to transform CHDP from a limited “safety net” program for children into a true point of entry to comprehensive health coverage. However, in order to accomplish this, the state must take steps to open the gateway.

We believe our recommendations move the state in this direction by (1) establishing new requirements for health care providers to encourage families to enroll in Healthy Families and Medi-Cal, (2) encouraging counties to help families apply for health coverage and streamlining the application process with a new on-line computer program, (3) centralizing and simplifying the application process for public health coverage, (4) preparing to improve CHDP’s data system, and (5) raising CHDP’s income eligibility level to match the income limits of Healthy Families.

Figure 6 summarizes the benefits of our recommended approach. We believe that reforming the CHDP program and its data system will improve the health of low-income children by extending more comprehensive free or low-cost health coverage to additional children under the Medi-Cal and Healthy Families Programs.

Our analysis suggests that the costs of making these improvements would be offset by savings to the state General Fund in the CHDP program, as CHDP clients enrolled in Healthy Families and Medi-Cal and as duplicate medical payments were

Figure 6

Benefits of the LAO Gateway Approach

- **Promotes comprehensive health coverage for low-income children** by enrolling CHDP clients in programs that offer a greater scope of services, including vision, dental, and prescription coverage, as well as visits to the doctor when the child is sick.
- **Reduces the number of uninsured children in California** whose lack of coverage has been associated with greater utilization of emergency room visits and higher costs for hospitals, and local and state governments.
- **Simplifies and improves for families** receiving CHDP services the process of applying for Medi-Cal and Healthy Families coverage.
- **Curbs General Fund costs in the CHDP program**, potentially in the tens of millions of dollars annually, by transferring the cost of health care to the Healthy Families and Medi-Cal programs for which the federal government bears a significant share of the costs.
- **Reduces county costs** for providing follow-up treatment for conditions diagnosed in CHDP screens, as CHDP clients enroll in Healthy Families and Medi-Cal and shift treatment costs to these programs.

eliminated. If, for example, 80 percent of the CHDP caseload was eventually determined to be eligible for Medi-Cal or Healthy Families, state costs for the program could be reduced by as much as \$80 million.

Shifting CHDP caseload to Medi-Cal would increase state costs for that program, but the enrollment of more CHDP clients in Healthy Families would not result in any significant additional state costs because the state has already budgeted for Healthy Families coverage for these children.



Acknowledgments

This report was prepared by Karin Bloomer and Gregory Jolivette, under the supervision of Daniel C. Carson. The Legislative Analyst's Office (LAO) is a nonpartisan office which provides fiscal and policy information and advice to the Legislature.



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