

Department of Human Services 2009-11 Policy Option Package

Division Name: Division of Medical Assistance Programs

Program Name: Healthy Kids Plan

Policy Option Package Initiative: Vulnerable Oregonians Have Access to Health Care

Policy Option Package Title: Healthy Kids Plan

Policy Option Package Number: 101, 111

Related Legislation: LC - GOV-06

Summary Statement:

The Healthy Kids Plan is an initiative led by Governor Kulongoski to give *all* uninsured Oregon Children, under age 19, an opportunity to enroll in comprehensive, affordable, health insurance coverage. The goal is to enroll 95% of *all* Oregon children into comprehensive health care. More than 116,000 Oregon children live without health insurance. DHS will lead the Healthy Kids Plan efforts in collaboration with the Office of Private Health Partnerships, Office for Oregon Health Policy and Research and stakeholders. This policy option package also includes funding to expand and sustain School-Based Health Centers to provide an estimated access to 3,000 to 7,000 additional students.

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Key Components

The Governor’s plan is to enroll all uninsured children in the Healthy Kids Plan. Following are the key components of the plan:

- All uninsured Oregon children up to age 19 will be eligible for coverage under the Healthy Kids Plan.
- The department will simplify the enrollment process by using existing programs and partnerships with schools, health care providers and non-governmental organizations.
- All kids in families with incomes no more than 200 percent of the federal poverty level (FPL) (\$42,408 for a family of four) will be eligible for comprehensive coverage through the existing Oregon Health Plan (OHP) and for employer sponsored insurance premium assistance through the Office of Private Health Partnerships (OPHP).
- Families with incomes above 200 percent of the FPL will be eligible to buy affordable comprehensive coverage for their uninsured children through a private insurance product called KidsConnect, including mental health and dental benefits.
- Subsidy payments from OPHP will be available for families from 200 through 300 percent of the FPL level to help defer the costs of their KidsConnect product; a sliding scale based on family income will determine the size of premiums and co-pays. Employer sponsored insurance premium assistance through OPHP will also be available.
- There will be no subsidy for families with incomes above 300 percent of the FPL.
- The department will engage in an aggressive outreach campaign that includes targeting the needs of racial and ethnic communities and other hard to reach areas.

- The Healthy Kids Plan will be funded with a combination of General Fund, Federal Funds and Other Funds, increasing the amount of federal dollars available to the state.

DHS Components of the Healthy Kids Plan to Aid in Implementation

DHS will administer the components of the Healthy Kids Plan concerning children in households with incomes of no more than 200 percent of the FPL, through the OHP Plus benefit package, which has no cost sharing or premium requirements. OPHP will administer the component of the HKP that includes children in families with incomes of 0 to 300% FPL who have access to Employer-Sponsored Insurance (ESI) and those with incomes over 200% of FPL in the KidsConnect product. DHS will administer the eligibility components for all children enrolling in HKP for both DHS and OPHP programs. Applications will be accepted through several doors, including DHS field offices, the Office of Private Health Partnerships (OPHP), outreach centers, health care providers, by mail and on-line. The DHS Statewide Processing Center will process the applications.

DHS also will be responsible for re-determining eligibility at reapplication or recertification. This includes sending out application/recertification packets. DHS will use the central call-in center and resulting application distribution through the existing contract with the Oregon State Correctional Institution (OSCI). DHS will establish a separate toll-free phone line specifically for the Healthy Kids Plan.

DHS is developing an on-line application as part of the Self Sufficiency Program (SSP) Modernization Program. The information entered on-line by a client, their representative or a DHS worker will populate the case file eliminating the necessity of re-entering the data. The project has begun and it is anticipated that it will be completed by June 2009, prior to the implementation of HKP. DHS also developed and implemented a shortened application at the beginning of 2008, making it easier for clients to apply for those without on-line access.

DHS and OPHP will work to minimize the workload through other process improvements and technology updates, improvements to application workflow technology, and simplified eligibility requirements. All Healthy Kids Plan

applications will be reviewed for eligibility in any Medicaid program to ensure the client received coverage to which s/he is entitled.

DHS will administer outreach and marketing and will continue to provide training and support related to OHP benefits and eligibility. The cost projections also include administrative costs for application packets, client handbooks, medical ID card printing, brochures, client notices, marketing and outreach efforts and other related materials.

Office for Oregon Health Policy and Research (OHPR) will monitor and evaluate the Healthy Kids Plan program performance. It will also develop and implement a biennial Children's Access to Health Care Survey to assess children's access to care, experience of care and health status. DHS has added a contract amount in the budget for these efforts. The administrative costs include one limited duration research position to support OHPR and assist with the evaluation and to produce reports on enrollment and performance/outcomes for program management. The budget also includes \$600,000 per biennium for the survey.

The DHS Office of Document Management (ODM) and the DHS Office of Information Systems will partner to increase the capacity of the current centralized imaging system, fax servers and workflow software to allow for additional dedicated fax lines and increased throughput. This will allow for local DHS offices to fax verification documents directly into the imaging system for subsequent eligibility determination, provide for storage in a central repository and allow simultaneous retrieval of data and information.

Children enrolled in the DHS portion of the Healthy Kids Plan and who are not enrolled in a managed care plan will be able to access the OHP Nurse Advice Line. Those identified as being at risk for a high level of healthcare utilization because of chronic or complex conditions, including the presence of one or more disorders, including common childhood chronic conditions such as asthma and diabetes, may also be eligible for the Disease Management/Medical Care Management (DM/MCM) program. The DM/MCM program provides coordination of

medical and ancillary services and takes a holistic, inclusive, collaborative, client-centered approach to improved self management skills, and enhanced health outcomes.

The DHS field office in Multnomah County is currently working with local school districts to link the school lunch program and DHS programs. Oregon Department of Education received a grant in 2007 to develop an online application that will be piloted in Multnomah. DHS would continue to work with this pilot, exploring opportunities to expand outreach and enrollment efforts.

Health care needs are trending upwards for Oregon's children & teens; rates of uninsured among 0-18 year olds are rising and are highest for older adolescents. Many students report unmet health care needs and are more likely to depend on school-based health centers (SBHCs) as a regular source of care. SBHCs have demonstrated their ability to reduce barriers to care and improve access to all youth regardless of insurance status, are an important component of the safety net system, and focus on a wide range of public health issues identified at the local, state, and federal levels. Not all counties are currently funded to develop this model and existing sites have identified need for support to sustain the model and improve the SBHC mental health system.

For the 2009-2011 biennium, DHS is proposing concepts that work towards the expansion and sustainability of the SBHC model. This proposal is based in part on a local needs assessment conducted in 2007-08 with school districts and local public health authorities that identified local interest in future expansion and informed DHS on barriers to starting and sustaining SBHCs as a system of care.

(a) Expansion: Expand the SBHC system by opening SBHCs in up to five new counties. In addition, allow up to seven counties with existing SBHCs to increase funding to 3-4 existing sites; expanding access to 3,000 to 7,000 additional students grades K-12.

(b) Sustainability: An increase to the current funding formula base for all SBHCs would support sustainability of the model. This increase would allow centers to improve the SBHCs' capacity to provide

mental health services, increase linkages to mental health services, and/or improve surveillance of mental health services through implementations of quality assurance measures, such as data reporting and referral monitoring.

2. WHY DOES DHS PROPOSE THIS POP?

More than 116,000 Oregon children live without health insurance, according to the most recent data available for 2006. This represents approximately (12.6) percent of Oregon's children.

In a May 2008 study by The Commonwealth Fund, Oregon ranked #43 on Child Health System Performance. The study addressed access, quality, costs, potential to lead healthy lives and equity. Oregon's highest ranking was in cost and potential to lead healthy lives. Oregon's lowest ranking was for equity, relating to income, race/ethnicity and insurance coverage.

These children lack access to doctors, medicine, eyeglasses, asthma inhalers, and the other health care services people with insurance take for granted. It is estimated that nearly half of these children may be eligible for coverage under one of Oregon's existing public programs but have not enrolled because of a variety of barriers including complexities of the application and eligibility process and lack of understanding of the importance of maintaining continuous health coverage. Thousands more are from working families who earn too much to qualify for those programs but not enough to pay for private insurance.

When children lack health care, everyone suffers. Kids without access to health care don't do as well in school. Their treatable illnesses and injuries go untreated making them more likely to end up in emergency rooms, where care is more expensive. They become sick more often and miss more school days, requiring their parents to stay home and care for them. This translates to lower productivity for employers. Insuring children increases opportunities for prevention and early diagnosis, and positively influences school success through good physical,

mental and dental care. It gives children a medical home, promotes regular medical and dental care, and reduces costly emergency room visits.

Based on the information from the expansion assessment, conducted in 2007-08, DHS proposes the expansion of school-based health centers to address the issue of limited access to health care for school-age youth and the increasing need for mental health care services. This expansion will provide access to health care services for more uninsured and underinsured school-age youth.

In 2006-07 a mental health expansion assessment was conducted. As a result DHS found the need for an increase in funding to support sustainability of the model and improve areas of SBHC mental health capacity (i.e. increase number of mental health providers and provider hours and/or increase mental health services) and surveillance (i.e. improve data reporting and referral monitoring).

3. HOW DOES THIS FURTHER THE AGENCY’S MISSION OR GOALS?

This furthers the agency mission in “assisting people to become independent healthy and safe.” It furthers all of the DHS goals, which are:

- People are safe
- People are healthy
- People are living as independently as possible
- People are able to support themselves and their families

School-Based Health Centers (SBHCs) assist youth to become “independent, healthy and safe” by providing them easy access to age and developmentally appropriate primary and preventive physical and emotional health care in a setting that supports families and communities by also complimenting and contributing to the educational mission for school-aged youth as research demonstrates ‘healthy kids learn better’. SBHCs are an increasingly important and growing component of the state’s system of safety net and community health centers. The services provided in a SBHC are supportive of important national public health objectives, including Healthy People 2010’s 21 critical

objectives for adolescent and young adults and the DHS Office of Family Health's Title V Maternal & Child Health national and state performance objectives (e.g., unmet health care needs, mental health and social emotional development).

4. IS THIS POP TIED TO A DHS PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS MEASURE THE SUCCESS OF THIS POP?

Because of the wide range of impact on Oregon’s children, this proposal links with the DHS 2009-11 proposed, Key Performance Measures (KPMs) and two of Oregon Benchmarks (OBMs):

KPM/PH: The percentage of 24-35 month old children who are adequately immunized per ACIP standard series.

KPM/DMAP: The rate of preventive services for youth and adults 11 years old and older covered by OHP – including racial/ethnic breakout

KPM/DMAP: The rate of preventive services for children birth through 10 years old covered by OHP – including racial/ethnic breakout

KPM/AMH: Percent of children receiving mental health services suspended or expelled from school

KPM/PH: Teen pregnancy

KPM/PH: Teen suicide

KPM/PH: Intended pregnancy

KPM/PH: 8th grade risk for alcohol and drug use

KPM/PH: Tobacco use

KPM/PH: HIV rate

KPM/PH: OHP clients receiving routine health care

KPM/PH: Safety net clinic use

Oregon Benchmarks:

OMB #42: Percent of two-year-olds who are adequately immunized

OBM #43: Number of 1st time positive HIV test results among Oregonians age 13 and older and rate per 100,000

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

STATUTORY REFERENCE:

The proposal will require amending and creating new statutes to implement this proposal. The statutes that will be affected are:

ORS 414.025	Definitions
ORS 414.725	Payment of deductibles as imposed under federal law
ORS 414.839	Subsidies for health insurance coverage
ORS 442.507	Assistance to rural emergency medical service systems
ORS 735.701	Office of Private Health Partnerships
ORS 735.710	Additional Duties of office; rules
ORS 735.754	System payment or reimbursement of subsidies and costs.

The expansion of SBHCs will not require a statutory change.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

To improve access to private health insurance coverage for more children in 2004, Governor Kulongoski developed a Children’s Group Insurance Plan in conjunction with the Office of Private Health Partnerships, formerly the Insurance Pool Governing Board. The Children’s Group Plan offers an opportunity for employers to,

at a minimum, provide coverage to the children of their employees. The plan became available in early 2005. Findings showed that only a small number of small businesses enrolled in the plan and it has since closed. This highlights the need for more affordable group coverage options for kids, which will be part of the Healthy Kids Plan.

The state School-Based Health Center program is based on a public health systems (infrastructure) approach to improve access to primary and preventive health care to school-aged youth. Twenty-four counties will currently have been funded by the end of the 2007-2009 biennium. No other alternatives were considered; however, DHS is working with the Oregon School-Based Healthcare Network and other state agencies on analyses and strategies related to services expansion as well as billing and reimbursement as a factor contributing to sustainability.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

A Robert Wood Johnson Foundation report noted that over 1 in 3 uninsured children went an entire year without a medical visit and uninsured children are 10 times more likely to miss out on needed medical care. With lack of access to routine and preventive health care, uninsured children may miss more school placing them at a disadvantage to succeed in school.

The uninsured have a financial impact on insured Oregonians. Through analysis published for OHP in 2007, Oregonians who have health insurance pay between 6-9% of their premium cost to help pay for care of the uninsured. Without additional insurance coverage for children, the insured will continue to pay the cost of care for the uninsured.

If DHS 'did nothing' few counties would proceed to develop the SBHC model independently and growth in the SBHC safety net would be minimal/marginal. Without this funding, the current mental health SBHC system would most likely stay the same and integration of primary care and mental health care within the SBHC model would not adequately progress. However, due to implementation of new key performance measures (i.e. risk assessments), there will most likely be an increase in identified mental health issues with limited capacity to address the needs.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

The Healthy Kids Plan will have an impact on many agencies. They include:

- Office for Oregon Health Policy and Research – They will be evaluating the program as well as conducting a survey on children’s health care access, experience of care and health status
- Office of Private Health Partnerships – OPHP will be developing a private insurance product called KidsConnect for children in families with incomes over 200% of the FPL, with state contributions for those with incomes of up to 300 percent FPL. They will also expand access to the state contribution for children in families with access to employer sponsored insurance (ESI).
- The Tribal Health Clinics will be compensated for services they provide to children in their clinics.
- Rural Health Clinics, Federally Qualified Health Centers, and Community Health Centers will be reimbursed for care they provide to children in managed care plans. They may also see a reduction in the populations they serve as more children become enrolled into managed care plans and use services provided by the managed care plan panel. There will be a financial impact because DMAP will be required to provide wraparound payments to these providers to supplement payment to them by the managed care plan.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

General Assumptions:

- Aggressive outreach for the Healthy Kids Plan would be implemented on July 1, 2009.
- Eligibility for DHS and OPHP ESI supplement program would be expanded from 185% through 200% effective October 1, 2009.
- The KidsConnect product for children over 200% FPL would be implemented January 1, 2010.

- The DHS product benefit plan would be the OHP Plus benefit package.

Administrative Structure:

- Eligibility would be administered through DHS, with some exceptions identified to increase program administrative efficiency. To maximize utilization of staffing resources, whenever possible screening and eligibility determination functions would not be separated.
- Outreach and marketing would be administered through DHS in coordination with OPHP; DHS would continue to provide training and support related to the Oregon Health Plan benefits and eligibility.
- OHPR would have responsibility for analysis and evaluation of the Healthy Kids Plan implementation, including marketing and outreach activities. They would also implement a biennial Children's Access to Health Care Survey to assess children's access to care, experience of care and health status. DHS would add a contract amount in the budget for these efforts.

Eligibility:

- Income limitations for OHP programs would not change with the exception of SCHIP. The SCHIP income limitation would be increased from 185% to 200% of the FPL. While the statute allows eligibility to no more than 200% of the FPL, funding currently is limited to 185% of the FPL.
- Income limitations for the Family Health Insurance Assistance Program (FHIAP) would be increased from 185% FPL to 200% FPL to coincide with the implementation of the Healthy Kids Plan.
- Income limitations for children to qualify for a premium subsidy for ESI would also be increased from 185% FPL to 200% of the FPL initially and expanded from 200% to 300% of the FPL to coincide with implementation of the KidsConnect product (KidsConnect) program.
- There would be no asset limit for eligibility in the Healthy Kids Plan.
- All children would be eligible. This includes undocumented children and children who would not meet federal requirements for eligibility due to citizenship status but are documented aliens and are otherwise eligible.

- The KidsConnect product would not be available to children in families with incomes under 200% of the FPL.
- No upper income limit would apply to eligibility for the KidsConnect product; however, no premium subsidy would be available for children in families with incomes above 300% FPL.
- A sixty-day period of uninsurance would be required for eligibility; however, exceptions would include the four existing criteria and one additional: loss of coverage due to loss of employment. The four existing criteria include:
 - The person has a condition that, without treatment, would be life-threatening or cause permanent loss of function or disability;
 - The person's private health insurance premium was reimbursed by DHS under the cost-effectiveness provision for employer sponsored health insurance premiums
 - The person's private health insurance premium was subsidized by OPHP (*This provision would be amended to reflect that receipt of an insurance premium subsidy from OPHP for the KidsConnect product is not an exception to the rule if a child is re-applying for a KidsConnect product subsidy – the net effect would be a two-month waiting period for the KidsConnect product*); or
 - A member of the person's filing group was a victim of domestic violence.
- Program eligibility alignment opportunities would be explored between DHS and OPHP to promote the seamless concept as well as to reduce administrative complexities.

Administrative Program Support:

- DHS would develop the ability to apply online prior to the implementation of HKP.
- Funds would be provided for the planning and development of additional School Based Health Centers.
- DHS would make improvements in the document imaging process to aid in automating application processing.
- DHS would replace or upgrade the current phone system to implement an automated voice response system to simplify reenrollment for the client.

Cost Sharing/Premium Subsidy:

- There would be no premiums or cost sharing (co-pays or coinsurance) in the DHS product benefit plan (children in families with incomes of no more than 200% of the FPL).
- Premiums and cost sharing would be required in the OPHP KidsConnect benefit plans. Premium subsidies would be determined by and paid through OPHP.
- Premium subsidies for ESI and the KidsConnect product for children in families with incomes between 200% and 300% FPL would be based on a sliding scale based on income. ESI product may have co-pays.
- Cost sharing could be higher for ESI and the KidsConnect product for children in families above 300% of the FPL to keep the cost of the private product available at a reasonable cost.

Outreach/Marketing:

- A 95% saturation at all income levels would be achieved by December 31, 2010.
- The budget would include funding to distribute materials or display ads throughout the state to help build and reinforce the Healthy Kids brand identity.
- DHS would administer an outreach and enrollment grant program. DHS would provide infrastructure funding, technical and training assistance, as well as publications and other promotional materials, while the organizations would provide staff experienced in the needs of their local community. The budget would assume 30 grants would be awarded at an average of \$50,000 each annually.
- Another element of the outreach and enrollment program would be a “bonus” or “challenge” grant to help defray additional expenses due to the challenges faced by their target population. The budget would assume 10 bonus grants at \$10,000 each annually.
- An application assistance fee program would be developed to award an application assistance fee to organizations or individuals who have assisted clients with the application process who are subsequently approved for DHS or OPHP programs. Pricing would assume approximately half of these targeted children under 300% of the FPL will need this type of assistance. Those receiving grant funds would not qualify for

an application assistance fee. Out-stationed outreach worker sites would not qualify for the application assistance fee or the grant programs.

Fiscal:

- Pricing would assume that Federal Financial Participation (FFP) would be available for services to children in families with incomes no more than 250% of the FPL in the Healthy Kids Plan for both DHS and OPHP. DHS would request FFP to cover children with incomes above 250% FPL; however DHS anticipates federal funds will be limited to the under 250% population.
- The DHS and OPHP programs will be priced using Title XIX funds. Projections indicate the Title XXI allotment will be expended and not available to cover these additional children.
- Time allocation and expenditure tracking/reporting would be required for non-FFP components (expenses related to services for children who would not meet federal requirements for eligibility due to citizenship status but are otherwise eligible, and costs related to services for children in families with incomes above 250% FPL who would be enrolled in the KidsConnect product or receiving ESI state contributions). An allocation formula will be required for the administrative costs to determine federal financial participation; program costs for the identified populations will be supported by state funds only.

Implementation Date(s): July 1, 2009 – Begin outreach and marketing, covering children no more than 185% of the FPL. Begin the development and expansion of SBHCs
October 1, 2009 – Expanding coverage to children no more than 200% of the FPL
January 1, 2010 – Implementing the private product and covering all children with state contributions for ESI and KidsConnect for the 200-300% FPL population.

End Date (if applicable): No end date, ongoing

a. Will there be new responsibilities for DHS? Specify which division(s) and describe their new responsibilities.

- | | |
|---|--|
| <input checked="" type="checkbox"/> Administrative Services | <input checked="" type="checkbox"/> Addictions and Mental Health |
| <input checked="" type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Public Health |
| <input checked="" type="checkbox"/> Division of Medical Assistance Programs | <input checked="" type="checkbox"/> Seniors and People With Disabilities |

This section includes administrative impacts (b.) and staffing (d.).

Division of Medical Assistance Programs

DMAP will be the lead in DHS for development and implementation of the Healthy Kids Plan. This will require one Project Manager (OPA3) to lead these efforts for DHS. DMAP/Research Unit will work with OHPR to evaluate the implementation and outreach of HKP, requiring a Research Analyst 3. DMAP Operations will need additional staff for the increased caseload for claims processing.

DMAP will have the added responsibilities for the development and oversight of a marketing and outreach program. This will include the development of a grant program and training for current and new outreach partners and Medical providers. This will require three new positions. One Public Affairs Specialist (PAS3) to lead outreach and education activities using two educators (OPA2), to travel the state to provide training. To support these activities DMAP will need \$135,552 for each biennium for travel and education activities. DMAP will also require two Grant Coordinators (OPA3) to oversee the outreach and enrollment grant program and the application assistance fee program. This will include awarding 30 grants at an average of \$50,000 annually and 10 grants at an average of \$10,000 annually to target hard-to-reach populations for a total of \$3,200,000 each biennium. There will also be application assistance fees of \$50 per eligible person enrolled to each organization or individual who helps clients successfully complete the application process. The projected

expenditures for the application assistance fee program are \$2,276,620 in 2009-11 and \$2,620,370 in 2011-13.

DMAP will need contracted services to assist DHS with submitting a waiver amendment request to the Centers for Medicare and Medicaid Services (CMS) to establish the OHP Demonstration project's Healthy Kids Plan. They will also provide expertise, knowledge, advice and consultation in the negotiation process with CMS in the effort to gain federal approval. The projected expenditure is \$150,000 each biennium.

DMAP position detail is listed below:

Position	Duration	2009-11 # Months	2011-13 # Months
Division of Medical Assistance Programs (DMAP):			
Operations Section			
1 - Public Service Representative 3 (CASU)	Permanent	24	24
1 - Public Service Representative 4 (Provider Services)	Permanent		24
1 - Medical Review Coordinator (RN in Medical Unit)	Permanent	24	24
1 - Administrative Specialist 2 (CASU)	Permanent		24
Research Education and Development Section			
1 – OPA 3 (HKP Program Coordinator in Special Projects)	Permanent	24	24
1 – Research Analyst 3	Permanent	24	24
2 – Outreach Grant Coordinator (OPA3)	Permanent	24	24
1 - Public Affairs Specialist 3	Permanent	24	24
2 – OPA 2 (Outreach & Education)	Permanent	24	24

Administrative Services

Office of Communications will be responsible for development and implementation of an initial communications, outreach and marketing campaign, as well as ongoing communications to promote this plan to parents and guardians of uninsured children. Both the initial campaign phase and the ongoing outreach efforts will require continued promotional efforts directly and through contracted partners, development and updating of informational materials, and ongoing communications with partners and providers to successfully outreach to the target audience. This will require \$1,934,800 in 2009-11 and \$1,500,000 in 2011-13.

Office of Communications position detail is below:

Position	Duration	2009-11 # Months	2011-13 # Months
Office of Communications			
1 - Public Affairs Specialist 3 – Marketing Officer	Limited	24	0
1 - Public Affairs Specialist 3 – Public Information Officer	Permanent	24	24
1 - Electronic Pub Design Specialist 3 – Publication Designer	Permanent	24	24

Office of Budget, Planning and Analysis will need one additional Budget Analyst (FA3) for the increase in work related to the increase in caseload for Healthy Kids.

Office of Budget, Planning and analysis detail is below:

Position	Duration	2009-11 # Months	2011-13 # Months
Office of Budget, Planning and Analysis			
1 – Fiscal Analyst (FA3)	Permanent	24	24

Office of Contracts and Procurement will be supporting DMAP with the outreach and enrollment grant program and the application assistance fee grant program with one limited duration position for the first year and permanent Contracts and Procurement staff will cover the on-going work for these grants. This will include 40 outreach and enrollment grants each year and 45,532 application assistance fees awarded in 2009-11 and 52,407 in 2011-13.

Office of Contracts and Procurement position detail is below:

Position	Duration	2009-11 # Months	2011-13 # Months
Contracts and Procurement			
1 - Procurement and Contracts Specialist 2	Limited	12	0

Office of Information Systems will be responsible for developing and maintaining a system that will support the process necessary to manage the application assistance fee program. The design will include necessary security and fraud controls to eliminate the possibility of duplicating payments and ensure payments are made for each eligible application. This will include modifications to systems including Electronic Data Management System (EDMS) and Client Maintenance System (CMS). The CMS will have a critical role in the process. The two Infrastructure Services Positions (ISS7) will be used for the development and maintenance of the system necessary for the application assistance fee program. OIS also needs an additional Service Desk Position (ISS4) to be used to support the Tier 1 and Tier 2 workload put on the team as a whole. This work is defined as anything from receiving and recording work requests, to resetting passwords and helping with login, to supporting the application use, to administering the security of the system user accounts.

Office of Information Systems position detail is below:

Position	Duration	2009-11	2011-13
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		# Months	# Months
Office of Information Systems (OIS)			
1 - Information Systems Specialist 4	Permanent	24	24
1 - Information Systems Specialist 7	Permanent	24	24
1 - Information Systems Specialist 7	Permanent	24	24

Office of Financial Services will have the added responsibility of monitoring and making payments for the application assistance fee and outreach and enrollment grants. The Accountant 4 will assist with the additional accounting workload related to processing and administration of the grants.

Office of Financial Services position detail is below:

Position	Duration	2009-11 # Months	2011-13 # Months
ASD/Office of Financial Services			
1 – Accountant 4	Permanent	24	24

Office of Payment Accuracy and Recovery will have an increase in Third Party Liability (TPL) research needed. An assumption could be made that there will be no TPL as these are uninsured kids that are coming on to the Oregon Health Plan. Research and monitoring TPL would still be required as an ongoing effort supporting the integrity of the Medicaid program. Other potential increases in OPAR caseloads (overpayment writing, fraud investigations, and recoveries) would be minimal and can most likely be absorbed through ongoing process improvement efforts.

Office of Payment Accuracy and Recovery position detail is below:

Position	Duration	2009-11 # Months	2011-13 # Months
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Office of Payment Accuracy and Recovery (OPAR)			
2 – Administrative Specialist 1	Permanent	24	24
1 – Office Specialist 2	Permanent	24	24

Office of Document Management (ODM) and the DHS Office of Information Systems (OIS) will partner to increase the capacity of the current centralized imaging system, fax servers and workflow software to allow for additional dedicated fax lines and increased throughput. This will allow for local DHS offices to fax verification documents directly into the Imaging system for eligibility determination, storage in a central repository and simultaneous retrieval of data and information. ODM will not have new responsibilities but will need an increase in staff to process the increase in applications at the Processing Center. To aid in processing new applications they will need new data processing hardware and software to manage the increase in applications for a total of \$1,377,097 for the 2009-11 biennium. There will also be ongoing costs for a fax line and professional services in 2011-13 for a total of \$97,896.

Office of Document Management position detail

Position	Duration	2009-11 # Months	2011-13 #Months
ASD/Office of Document Management			
3 – Data Entry Operators	Permanent	24	24
4 – Data Entry Operators	Permanent		24
1 – Data Entry Control Technicians	Permanent	24	24
1 – Support Services Supervisor 3	Permanent	24	24

Office of Health Policy and Research will have new responsibilities monitoring and evaluating the impact of the Healthy Kids program. Funding in this POP will provide for development of a

comprehensive evaluation of the Healthy Kids program and the implementation of a biennial Children's Access to Health Care Survey to assess children's access to care, experience of care and health status. This will be done in coordination with the Research Analyst 3 in DMAP. They are requesting \$600,000 each biennium to complete the survey.

Office of Health Policy and Research position detail:

Position	Duration	2009-11 # Months	2011-13 # Months
ASD/Office of Health Policy and Research (OHPR)			
1 - Research Analysts 3	Permanent	24	24

Children, Adults and Families Self Sufficiency Program (SSP) will require additional positions for the eligibility determinations and redeterminations for all children in the HKP program, as CAF SSP staff process eligibility determinations for both DHS and OPHP programs. Current HSS2's at the Statewide Processing Center will determine eligibility for multiple programs; since this includes responsibilities above their current level of classification they will be re-classed as HSS3's. Processes will need to be implemented to allow for the transfer of client demographic data to the Office of Private Health Partnerships when the family income for the child exceeds the income levels of DHS programs to allow private insurance enrollment and establishment of state contributions subject to the eligibility determination. CAF will also need two Human Services Specialists for outreach activities related to the application assistance fee program.

Children, Adults and Families position detail:

Position	Duration	2009-11 # Months	2011-13 # Months
Children, Adults and Families (CAF)			

16- Human Services Specialist 3 (13.67 FTE)		24	
27 - Human Services Specialist 3 (26.24 FTE)			24
7 - Human Services Specialist 1 (7.0 FTE)		24	24
1 - Human Services Specialist 4 (1.0 FTE)		24	24
1 – Operations & Policy Analyst 3(1.0 FTE)		24	24
1 – Principal Executive Manager B (1.0 FTE)		24	24
62 - HSS2's reclassified to HSS3's at a cost of \$511,872			

Additions and Mental Health will have an increase in children being enrolled into Mental Health Organizations. They will not have additional administrative expenses.

Seniors and People with Disabilities anticipate a very small number of new enrollments in their program, as they believe that disabled children who qualify for services in Oregon are already enrolled in DHS programs, including medical.

The Office of Private Health Partnerships will be contracted by DHS, administered by DMAP, to provide Education, Outreach and Marketing services to targeted stakeholders and clients over 200% of the FPL Guidelines. The budget includes personal services, services and supplies, and marketing.

Public Health will not require additional staff or administrative costs for the expansion of School-Based Health Centers.

b. Will there be new administrative impacts sufficient to require additional funding? Specify which office(s) and describe how it will be affected.

- | | |
|--|---|
| <input type="checkbox"/> Human Resources | <input checked="" type="checkbox"/> Payment Accuracy and Recovery |
| <input type="checkbox"/> Information Security/Privacy | <input type="checkbox"/> Investigations and Training |
| <input checked="" type="checkbox"/> Document Management | <input checked="" type="checkbox"/> Facilities |
| <input type="checkbox"/> Audit and Consulting | <input checked="" type="checkbox"/> Contracts and Procurement |
| <input checked="" type="checkbox"/> Information Services (computers) | <input checked="" type="checkbox"/> Budget, Planning and Analysis |
| <input checked="" type="checkbox"/> Financial Services (accounting) | <input checked="" type="checkbox"/> DHS Office of Communications |
| <input type="checkbox"/> Other (Specify below) | |

See (a.) above

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

There will be significant increases to client caseloads.

Healthy Kids Universal Access: Biennial Averages – 18-month uptake

Total Populations to be Taken Up	09-11	11-13.
OHP PLM/TANF		
0 to 100% FPL (24 mo. avg.)	13,324	17,215
100 to 185% FPL (24 mo. avg.)	397	518
AB/AD		
0 to 100% FPL (24 mo. Avg.)	669	864
SCHIP		
100 to 185% FPL (24 mo. avg.)	12,600	16,273

185% to 200% FPL (21 mo. avg. in 2009-11 only)	13,248	17,718
Not Federally Qualified: Documented PLM/TANF		
0 to 100% FPL (24 mo. avg.)	156	201
Not Federally Qualified: Documented SCHIP		
100 to 185% FPL (24 mo. avg.)	145	187
185 to 200% FPL (21 mo. avg. in 2009-11 only)	147	187
NOT Documented PLM/TANF		
0 to 100% FPL (24 mo. avg.)	612	791
NOT Documented SCHIP		
100 to 185% FPL (24 mo. avg.)	568	734
185 to 200% FPL (21 mo. avg. in 2009-11 only)	579	734
CAWEM Transfers <100% FPL (PLM/TANF)		
Documented (24 mo. avg.)	1,425	1,619
Undocumented (24 mo. avg.)	5,702	6,475
ESI		
0 – 100% FPL (24 mo. avg.)	777	1,004
100 to 185% FPL (24 mo. avg.)	716	933
185 to 200% FPL (21 mo. avg. in 2009-11 only)	735	933
200 to 250% FPL (18 mo. avg. in 2009-11 only)	207	256
250 to 300 % FPL (18 mo. avg. in 2009-11 only)	207	256
>300% FPL (18 mo. avg. in 2009-11 only)	0	0
KidsConnect		
200 to 250% FPL (18 mo. avg. in 2009-11 only)	3,933	4,862
250 to 300% FPL (18 mo. avg. in 2009-11 only)	3,933	4,862
>300% FPL (18 mo. avg. in 2009-11 only)	6,507	7,855

Sum of Average Monthlies	59,465	75,458
Total 24 Month Average	53,929	75,458

Funding for SBHCs will provide an estimated access to 3,000 to 7,000 additional students grades K-12. There may be an increase in mental health services provided in the SBHCs.

- d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.**

See (a.) above for Healthy Kids Plan. Public Health does not require new staff or position changes.

- e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?**

Start-up costs for computer systems include:

- New Requirements for the MMIS Enhancements will cost \$250,000 (2009-11 only)
- HKP ID Card Programming will cost \$26,000 (2009-11 only)
- New hardware and software for ODM at a cost of \$1,377,097 (2009-11 only) and ongoing costs of \$97,896 for 2011-13
- System development by OIS staff for management of grant programs includes 2- ISS7's listed above.
- Adding an automated voice response system to the processing center will allow clients to provide current information by phone, 24 hours a day, to aid in reenrollment. The start-up costs will be \$500,000 for development in the first biennium. The monthly maintenance will be \$360,000 for each biennium.

Materials

- DMAP will need additional materials for the increase in caseload, including the addition of the OPHP clients, to include application packets, medical ID, client letters, client handbooks, newsletters and reapplication packets. In 2009-11 biennium - \$514,507, 2011-13 biennium - \$641,147.
- Office of Communications will develop marketing materials to promote HKP at a cost of \$1,934,800 in 2009-11 and \$1,500,000 in 2011-13

Outreach training

- Training and travel expenses of two educators in DMAP to train outreach partners will cost \$135,554 per biennium.

Outreach grants

- Application assistance fees will total \$2,276,620 in 2009-11 and \$2,620,370 in 2011-13. The outreach and enrollment grants will total \$3,200,000 for each biennium. Both programs will be administered by DMAP.

OPHP activities

- OPHP will provide education, outreach and marketing services to targeted stakeholders and clients over 200% of the FPL Guidelines.

f. What are the ongoing costs?

This will be an ongoing program that will include an increase in caseload and an increase in staffing to handle the caseload increase. The marketing, outreach and enrollment strategies will continue.
(See attached budget)

Public Health is requesting \$480,000 for each biennium for an increase to the currently approved base funding for SBHCs. This represents a 10% increase from 2007-09 base funding. The expansion request for SBHCs is \$900,000 each biennium.

g. What are the potential savings?

Unknown

h. Based on these answers, is there a fiscal impact?

Yes

i. What are the sources of funding and the funding split for each one? Include grant names and fund type, such as “Medicaid, General and Federal Funds.”

Medicaid, SCHIP, General Funds and Other Funds. The Other Funds will be identified by the Governor’s Office.