

Department of Human Services 2009-11 Policy Option Package

Division Name: Division of Medical Assistance Programs

Program Name: Oregon Health Plan (OHP) Standard Program

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

Policy Option Package Title: Continuation and/or Expansion of the OHP-Standard Program

Policy Option Package Number: 121, 131, 141, 151

Related Legislation: Not Applicable

Summary Statement:

This package has four components that would continue and/or expand the OHP-Standard program. These components would allow the department to continue OHP-Standard with General Fund dollars with 62 percent federal match; would enroll all eligible applicants who apply; would change the OHP-Standard adult eligibility period from six to 12 months; and would improve the OHP-Standard benefit package to match the benefits in the OHP-Plus package.

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

This package would significantly increase the number of insured Oregonians while also reducing the rate of uninsurance among Oregonians.

General Fund support: The first component, supporting OHP-Standard with General Fund, would permit the program to continue for a monthly average of 24,000 adults. Without General Fund, the program would end sometime in 2010 as a result of the October 2009 sunset of provider taxes on hospitals and Medicaid managed care plans. Continuing OHP-Standard also would deliver coverage to approximately 3,000 people who were transferred from the state Family Health Insurance Program in June 2008, and who are expected to continue coverage in 2009-11. General Fund support would be complemented by 62 percent federal match and client premiums.

If this component were adopted by the Legislature, the department would not need increase staffing or implement any policy changes. This only uses General Fund dollars for OHP-Standard so that the department can maintain the program at its current level through the 2009-2011 biennium. The department would need authority to use General Fund dollars for a number of positions that are currently supported by provider tax revenue.

Open eligibility: This component would authorize the department to open OHP-Standard to anyone who applies for medical assistance and meets the eligibility criteria. Since July 2004, OHP-Standard was closed to new enrollment until March 2008, when the agency reopened it to bring the number covered to budgeted levels.

In July 1995, when eligibility requirements similar to today's program and enrollment was at its peak, OHP-Standard enrolled more than 100,000 adults. As recently as 2002, the program insured almost 100,000

clients. It is therefore conceivable that more than 90,000 people could enroll in the program if it were open to any eligible adult who applied.

After the department closed the program to new applicants in mid-2004 because of budget constraints, the caseload dropped to fewer than 18,000 people. In early 2008, the department accepted names for a reservation list and received more than 91,000 names. In March 2008, the department started mailing 3,000 applications a month to names randomly selected from the reservation list with a goal of achieving an average monthly caseload of 24,000 for the 2007-2009 biennium.

The department would implement this component by amending administrative rules to allow any uninsured adult applying for medical assistance to be evaluated for OHP-Standard eligibility. Just prior to the effective date of the rule change, the department would very likely mail applications to all the remaining names on the reservation list. Because of the anticipated influx of applications following the implementation of the rule change, the department would need to hire temporary staff to help process applications and determine eligibility. The department would also need additional permanent staff to serve the increased caseload.

12-month eligibility: The third component would increase the eligibility period for adults on OHP-Standard to 12 months instead of the current six months. Anyone applying for benefits on or after the effective date of this change would have 12-month eligibility. This includes anyone new to OHP-Standard, anyone moving from the Plus benefit package to Standard and anyone reapplying for Standard coverage.

Improved benefit package: The fourth component increases benefits to clients receiving the OHP-Standard benefit package to match the benefits in the OHP-Plus package. The OHP-Standard package was implemented in 2003 to serve more Oregonians with different benefits. This component would return OHP-Standard benefits to pre-2003 levels, providing all of the eligible population with OHP-Plus benefits.

Currently, OHP-Standard clients have access to physician services, prescription drug coverage, emergency/urgent hospital services, lab and X-ray services and a range of other services, but only limited dental, durable medical equipment, home enteral/parenteral, hospital and vision services. They have no services for acupuncture; chiropractic and osteopathic manipulation; hearing aids; home health; non-emergency medical transportation; occupational therapy; physical therapy; private duty nursing; speech and language therapy. They have no vision services for frames, lenses, contacts to correct vision or eye exams for the purpose of prescribing glasses or contacts. This component would restore these benefits.

2. WHY DOES DHS PROPOSE THIS POP?

The department proposes this package of improvements to OHP-Standard to continue the program, to open enrollment to more adults, to improve continuity of health care and to put OHP-Standard health services on a par with those of OHP-Plus, the dominant element of the Oregon Health Plan.

General Fund support: The department proposes the General Fund support to continue the Standard program, which the state now finances with provider taxes that will sunset October 2009. Continuing OHP-Standard would provide health care coverage to a monthly average of 24,000 adults during the biennium, reduce uncompensated care and prevent a corollary increase in the number and percentage of uninsured Oregonians.

Open enrollment: This component recognizes the significant unmet need for health care coverage among low-income adults who would qualify for OHP-Standard, with income below the federal poverty level. OHP-Standard covered more than 100,000 Oregon adults at its peak in July 1995.

12-month eligibility: DHS proposes this component not only because of the need for continued health care for this population, but also because of the long-term positive financial impacts of extended eligibility for preventive care, continuity of care, chronic disease management and reducing emergency room visits. Many

adults, who tend to be less healthy, do not reapply for OHP-Standard benefits as a result of earnings above the income limit, owing premiums or mobility. This component would benefit managed care organizations, which are given more time to reap the benefits of investments in preventive care. Also, research shows that when adults have health care services they are more likely to enroll their children in a health care plan. Therefore, this component also supports objectives of the Governor's Healthy Kids Plan.

Improved benefit package: The fourth component allows DHS to provide a more comprehensive package of health care services for the population receiving Standard benefits. This also benefits providers who now have to administer two different OHP benefit packages and who sometimes bear the cost of services not covered by OHP.

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

The department's mission is assisting people to become independent, healthy and safe. To assist people with being independent and healthy, the OHP-Standard program provides medical assistance to uninsured adults with income below the federal poverty level and who don't qualify for traditional Medicaid programs or Medicare. From March through October 2008, the department used a reservation list from which it monthly randomly draws names to receive applications for the program. More than 91,000 names were put on the reservation list, suggesting a dramatic demand for health care by Oregonians who considered themselves to be both low income and uninsured.

OHP-Standard is a fundamental component of the Oregon Health Plan as it was launched in February 1994. Under the Oregon Health Plan Medicaid demonstration project, the federal government authorizes Oregon to use Federal Funds for uninsured adults who don't qualify for traditional Medicaid programs or Medicare. By using General Fund dollars to continue OHP-Standard, the state avoids possible jeopardy to federal approval of the demonstration project.

Opening enrollment to all eligible adults would increase the state's rate of insured. Extending the eligibility period from six months to 12 would improve health outcomes for those whom OHP-Standard does cover, as would improving the OHP-Standard benefit to match that of OHP-Plus.

Prevention services are important for keeping people healthy, increasing opportunities for prevention and early diagnosis. They also reduce the chance of untreated chronic disease and severe medical conditions. The lack of prevention and early treatment leads to more cost to Medicaid and providers of uncompensated care as conditions worsen. Costs for uncompensated charity care are ultimately shifted to premiums paid by insured patients and their employers. Increased health care coverage would increase preventive care and improve outcomes for clients and communities.

Continuity of care is a vital factor in improving the health of people with already-diagnosed conditions who should not have a break in treatment, resulting in conditions that worsen and costs that rise. This initiative directly aligns with the department's goal that people are independent and healthy by providing increased services, including preventive services and comprehensive treatment.

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?

Two components of this package are tied to performance measures; two are not.

Continuing OHP-Standard with General Funds is not tied to a performance measure. This component would neither create a new program nor expand an existing one. Instead, it would allow the department to maintain OHP-Standard by replacing revenue from hospitals and Medicaid managed care plans with General Fund dollars.

Likewise, opening OHP-Standard enrollment to all income-eligible Oregon adults is not tied to a performance measure. The department would measure success by working with the Office for Oregon Health Policy and Research to study the impact of providing OHP-Standard coverage to thousands of uninsured adults. Specifically, the research would examine the impact on health status, emergency department usage, uncompensated care and the effect on enrolling eligible children.

Extending the eligibility period to 12 months is related to a proposed performance measure for the 2009-2011 biennium: The rate of hospitalizations for ambulatory care-sensitive conditions of Oregon Health Plan clients. Ambulatory care-sensitive conditions involve diagnoses where timely and effective ambulatory care can help prevent or reduce the risk of hospitalizations. Because many people in the Standard population need management of chronic disease, this component helps reduce hospitalizations.

Improving the OHP-Standard benefit package aligns with three DHS performance measures:

- Performance measure 26, which measures the proportion of racial and ethnic clients who receive health care annually;
- Performance measure 27, which measures the percentage of uninsured Oregonians served by safety net clinics;
- Performance measure 26, which measures the portion of clients who receive services annually.

Performance measures 26 and 27 are not tied to the Oregon Benchmarks, but instead to DHS High Level Outcome E, the percentage of Oregonians with access to physical health care. It also aligns with a proposed performance measure that measures the rate of ambulatory care-sensitive condition hospitalizations of OHP clients, because the agency is emphasizing preventive care for such conditions.

Components 1, 2, and 4 link with the high-level outcome E to increase the percentage of Oregonians with access to physical health care because the one-year eligibility period would keep people insured longer.

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.

For continuing OHP-Standard with General Fund, the legislature would not need to change existing statute or adopt a new statute. Current statutes (ORS 414.025(2)(r) and ORS 414.708(5)) give the department authority to provide coverage to individuals covered by OHP-Standard. This component would simply provide General Fund dollars for the program.

For opening enrollment to more eligible adults, the Legislature would not need to change existing statute or adopt a new statute. Current statutes (ORS 414.025(2)(r) and ORS 414.708(5)) give the department authority to provide coverage to individuals eligible for OHP-Standard.

No changes to existing statutes or new statutes are needed to extend the eligibility period to 12 months.

No legislation is needed to align the OHP-Standard benefit package with that of OHP-Plus. A Waiver amendment is needed as well as changes to the Department's Administrative Rules.

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

For use of General Fund and opening enrollment, the department did not consider any alternatives; however, the department recognizes that the Oregon Health Fund Board (established by Chapter 697, Oregon Laws 2007) is developing recommendations for financing health care in Oregon, including funding for the OHP-Standard program. Specifically, it is possible that the Board may propose broad-based provider taxes, health care transaction taxes, and/or payroll taxes to generate revenue to support the expansion of health care coverage in a number of programs including maintaining and expanding OHP-Standard.

For the eligibility period, the alternative is to leave eligibility for adults who qualify for OHP-Standard at the current six months. However, six months does not adequately meet the needs of this population whose health usually is poorer and benefits from longer preventive care and treatment for chronic and other conditions.

For improving the OHP-Standard benefit package, an alternative is to add some of the benefits eliminated in 2003. The agency rejected that option because the full range of benefits under OHP-Plus would have a greater impact on the health of the OHP clients than a partial restoration. Another option is to retain today's limited benefits for this population. With changes to the Health Services Commission's Prioritized List, the state is putting greater emphasis on preventive and primary services; therefore, retaining existing benefits is contrary to state goals and measurements of success.

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

Without General Fund support (or some other state funding source), OHP-Standard would end. If that were to occur, the federal government might revoke its authorization of the Oregon Health Plan demonstration, given that the Medicaid expansion was one of the demonstration's key elements. Lack of General Fund support results in thousands of Oregon adults' losing coverage, with adverse health consequences; losing the Oregon Health Plan demonstration would mean losing elements such as the unique and cost-saving Prioritized List of medical conditions and services.

If enrollment is not opened to all income-eligible adults, 90,000 or more uninsured low-income adults would continue to be without coverage, result in poorer health outcomes, more uncompensated care and a greater share of Oregonians being uninsured.

If the eligibility period is not increased to 12 months, many adults in relatively poor health will not enjoy the benefits of continuity of preventive care and treatment for medical conditions. In addition, these

households' children – they are more likely to be covered if parents are – are less likely to be covered in those households where the eligible adult has children.

If OHP-Standard benefits continue to be less than those for OHP-Plus, covered adults can be expected to have poorer health outcomes and to seek uncompensated care more often. Medicaid managed care organizations and fee-for-service providers would continue to have the administrative labor and expense of administering two separate OHP benefit plans.

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

Substituting General Fund for provider taxes that are ending would allow the department to continue to provide health care coverage under the OHP-Standard program to thousands of uninsured Oregonians. Tribes and local governments would experience a negative impact if this component were not approved. Without General Fund support (or some other state funding source), the department would need to end OHP-Standard, eliminating coverage for thousands of uninsured adults. Tribes and local agencies that provide health care services would experience an increase in uninsured patients seeking uncompensated care.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): October 1, 2009 (open eligibility), January 1, 2010 (12-month eligibility and improved benefit package) and November 1, 2010 (General Fund support, based on estimate of when provider taxes will be gone).

End Date (if applicable): Ongoing

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

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

The department would not have new responsibilities; however, the Division of Medical Assistance Programs would have increased program and administrative costs for covering more people on the OHP-Standard program. Children, Adults and Families, and Seniors and People with Disabilities would also have increase administrative costs because of the increase caseload.

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

- | | |
|--|--|
| <input checked="" type="checkbox"/> Human Resources | <input 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 type="checkbox"/> Contracts and Procurement |
| <input checked="" type="checkbox"/> Information Services (computers) | <input type="checkbox"/> Budget, Planning and Analysis |
| <input type="checkbox"/> Financial Services (accounting) | <input type="checkbox"/> DHS Office of Communications |
| <input type="checkbox"/> Other (Specify below) | |

Open eligibility: The Office of Document Management would need additional staff and possibly additional imaging equipment to handle the increased OHP-Standard caseload. The department would possibly have additional facility needs with housing additional eligibility staff at the Central Processing Branch in Salem.

Improved benefit package: This would result in increased staffing for DMAP, which impacts Human Resources and Facilities.

12-month eligibility: Document Management would have fewer applications to image due to the increased eligibility period, but the impact is not significant enough to lead to savings. Information Services would need to change programs to reflect the new eligibility period, but the costs are not significant enough to require funding.

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

General Fund support: The OHP-Standard program caseload would maintain an average monthly caseload of 24,000 clients and an additional average monthly caseload of approximately 3,000 former Family Health Insurance Assistance Program (FHIAP) clients who transferred into OHP-Standard in June 2008 and who are projected to remain in the program during the 2009-2011 biennium. Services provided under OHP-Standard would not change.

12-month eligibility: This component would not result in new caseload. OHP-Standard is closed to new enrollment, except for limited openings to bring the population to the monthly average of 24,000 people when the average is reduced by attrition. Changing the length of eligibility would decrease the rate of attrition. DHS currently is managing a reservation list of potential clients, and we allow about 3,000 people from this list per month to apply for Standard. If the attrition rate decreases, the number allowed to apply from the reservation list would be modified to keep enrollment at 24,000.

Open eligibility: Although the benefit package would not change, the OHP-Standard caseload would dramatically increase from its current level. If the fourth component were implemented, tens of thousands of people would be added to OHP-Standard over several months. In the first month,

approximately 50,000 clients are projected to enter the program. Within about six to eight months, the caseload would reach its new high of possibly 110,000 clients. During initial implementation, caseload increases would be limited by the capacity of staff to determine eligibility and input cases on the computer system.

- 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.**

General Fund support: No new positions would be needed; however, General Fund dollars would be needed for 27 positions currently funded by tax revenue. The permanent positions currently funded by provider tax revenue are the following:

4 DMAP Positions

- 1 – Public Service Representative 3, Position No. 1000417 (C0323; salary range 15)
- 1 – Administrative Specialist 1, Position No. 9400802 (C0107; salary range 17)
- 1 – Executive Support Specialist 1, Position No. 1410118 (C0118; salary range 17)
- 1 – Operations and Policy Analyst 2, Position No. 1410008 (C0871; salary range 27)

23 CAF Positions

- 9 – Human Services Specialist 2 (C6658; salary range 17)
- 11 – Public Service Representative 3 (C0323; salary range 15)
- 2 – Principal Executive/Manager B (X7002; salary range 26)
- 1 – Operations and Policy Analyst 3 (C0872; salary range 30)

Improved benefit package: The increase in services would result in the following additional FTE: 1 permanent full-time FTE Medical Review Coordinator (SR 28) and 1 permanent full-time FTE Public

Service Representative 4 (SR 19), beginning November 1, 2009. These positions would log in, review, and approve or deny the increase in prior authorizations for services.

There would also be 2 limited duration full-time FTE Public Service Representatives 4 (SR 19) starting November 1, 2009, and ending August 1, 2010, to manage the influx of phone calls during the initial implementation. One position would manage the calls from clients, and the other positions would answer calls from providers.

There would be 1 limited duration full-time FTE Administrative Specialist 2 (SR 19) starting November 1, 2009, and ending May 1, 2010. This person would augment the client services enrollment/disenrollment team due to the increases in services that would result in more clients' requesting an open card.

Open eligibility: The department would need limited duration staff (for six to 12 months) to handle the initial influx of OHP-Standard applications. The department would also need new permanent staff to handle the ongoing increased OHP-Standard caseload. The Division of Medical Assistance Programs would need the following four new permanent positions for the increased OHP-Standard caseload:

- 1 – Public Service Representative 3 (C0323; salary range 15) in the Client Services Unit
- 1 – Administrative Specialist 2 (C0108; salary range 19) in the Client Services Unit
- 1 – Public Service Representative 4 (C0324; salary range 19) in the Provider Services Unit
- 1 – Medical Review Coordinator (C6210; salary range 28N) in the Medical Unit

The Children, Adults and Families Division would need the following temporary positions (for six months) for processing and determining eligibility for OHP-Standard applications during the initial period:

- 34 – Human Service Specialist 2 (C6658; salary range 17)

17 – Human Service Specialist 1 (C6657; salary range 15)

The Children, Adults and Families Division would need the following new permanent positions for processing and determining eligibility for the ongoing OHP-Standard caseload:

42 – Human Service Specialist 2 (C6658; salary range 17)

21 – Human Service Specialist 1 (C6657; salary range 15)

5 – Principal Executive/Manager B (X7002; salary range 26)

3 – Human Service Specialist 4 (C6660; salary range 22)

The Senior and People with Disabilities Division would need the following new permanent positions for processing and determining eligibility for ongoing OHP-Standard cases for individuals over 60 years of age:

2 – Human Service Specialist 3 (C6659, salary range 19)

1 – Office Specialist 2 (C0104; salary range 15)

The Office of Document Management would need the following new permanent positions to handle the ongoing increased OHP Standard caseload:

- 22 – Data Entry Operators (C0501; salary range 11)
- 1 – Data Entry Control Tech (C1475; salary range 12)
- 1 – Principal Executive/Manager B (X7002; salary range 26)

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

Improved benefit package: There would be revisions to information and educational materials for clients and providers and some IT changes with the first component. Any IT changes can be absorbed.

The informational and educational material would have an estimated cost of \$50,000 to print, translate and mail materials.

12-month eligibility: This would not result in any costs for new materials, outreach or training. Changes to the Medicaid Management Information System and the Client Maintenance System are not significant and would not result in higher costs.

f. What are the ongoing costs?

Improved benefit package: This would increase health services payments.

General Fund support: This component would replace Other Funds (tax revenue) with General Fund dollars to maintain the OHP-Standard program at an average monthly caseload of 24,000 clients with an additional average monthly caseload of approximately 3,000 former Family Health Insurance Assistance Program (FHIAP) clients who transferred into OHP-Standard in June 2008 and who are projected to remain in the program during the 2009-2011 biennium.

12 month eligibility: Because OHP-Standard is maintained at 24,000 enrollees, the third component would not result in ongoing program costs.

Open eligibility: The department would have ongoing costs associated with a dramatically higher OHP-Standard caseload. Costs would include: permanent staff to handle the ongoing increased OHP-Standard caseload; increased program costs for fee-for-service and managed care capitation payments; increased administrative costs for more (new and redetermination) application packets, printing and postage for client mailings, and Medical ID cards.

g. What are the potential savings?

Improved benefit package: In the long term, there should be savings from better health outcomes for OHP clients with the first component. In the short term, adjustments would be made to reflect some decreases in the use of physician, prescription drug and hospital services that were compensating for increased acuity resulting from non-coverage of certain hospital and other services today.

12 month eligibility: There would be no savings in the near future. Over time, savings should accrue both to the health care industry and the state as the health of OHP clients improves.

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.”

Improved benefit package: Federal Title XIX Medicaid funds (63.02%) and state General Fund (36.98%).

General Fund support: This would replace Other Funds (hospital and Medicaid managed care organization tax revenue) with General Fund dollars. The General Fund dollars would be used with the client-paid premiums and Title XIX Federal Funds to pay for OHP-Standard expenditures. The Medicaid match rate would be used.

Open eligibility: This would authorize the department to open the OHP-Standard program using General Funds, client-paid premiums and Title XIX Federal Funds. The hospital tax and Medicaid managed care tax that support the current program will expire in state statute effective October 1, 2009. Client-paid premiums and Title XIX Federal Funds would continue to help pay for OHP-Standard expenditures. The Medicaid match rate would continue to be used - Federal Title XIX Medicaid funds (63.02%) and state General Fund (36.98%).