

**Department of Human Services
2009-11 Policy Option Package**

Division Name: Division of Medical Assistance Programs

Program Name: Oregon Health Plan Plus Program

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

Policy Option Package Title: Prenatal Expansion Program

Policy Option Package Number: 181, 171, 161

Related Legislation: Not Applicable

Summary Statement:

This three-component package would reduce the risk of negative birth outcomes for thousands of Oregon women by expanding access to prenatal care. Negative birth outcomes, such as low birth weight resulting from lack of prenatal care, increase Medicaid costs. This package would expand income eligibility for pregnant women and their infants from 185 percent of the federal poverty level to 200 percent; start prenatal care earlier by permitting document-supported presumptive eligibility while full eligibility is being determined; and make statewide a two-county pilot for women who are either undocumented or who are documented but haven't met the five-year residency requirement.

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

This package combines three complementary components to improve women's and infants' health.

The first would increase the number of women eligible for prenatal care and the number of infants receiving health care. It would do this by increasing income eligibility for pregnant women and their infants from the current 185 percent of the federal poverty level to 200 percent. This would cover women who, while technically not living in poverty, earn far too little to pay for health care insurance.

By amending state statute, the second would reduce delays in receiving prenatal care for women who are very likely eligible for OHP-Standard; in July 2006, 30 states used presumptive eligibility to improve birth and other health outcomes and reduce health care costs. It would do this by authorizing qualified, trained providers to approve presumptive OHP-Plus eligibility for ambulatory health care services to low income women. Presumptive eligibility would continue while long-term eligibility is being determined. If the woman is

ultimately found eligible, the eligibility period would begin on the date the provider approved presumptive eligibility; presumptive eligibility would end once DHS determines eligibility or, if the woman fails to submit an application, at the end of the month after presumptive eligibility begins. Only one presumptive eligibility period would be permitted for a pregnancy.

The third component would extend statewide a pilot in Multnomah and Deschutes counties to provide prenatal care to women who otherwise would be eligible only for emergency medical (including labor and delivery). These women now qualify for Citizen/Alien-Waived Emergency Medical (CAWEM), federally required emergency services for women who are undocumented or who are documented but haven't met the five-year residency requirement. This would make them eligible for OHP-Plus benefits, including prenatal services, building on what was learned during the 15-month two-county pilot that ends June 30, 2009. Services would be financed by the State Children's Health Insurance Program, or SCHIP, which receives 74.11 percent federal match.

2. WHY DOES DHS PROPOSE THIS POP?

Effective prenatal care that begins during the pregnancy's first trimester is critical to helping women modify harmful health behaviors, it delivers care for the mother and child, and it can identify and treat high-risk pregnancies. The results of early prenatal care are proven, and there is evidence low-income women will use these services if available.

Prenatal care reduces the likelihood of complications during pregnancy and childbirth, with national studies showing that \$1.70 to \$3.38 is saved for every dollar invested. The U.S. Department of Health and Human Services reports that lack of prenatal care triples the risk of low birth weight, which can require neonatal intensive care costing up to \$6,000 a day.

Many uninsured Oregon women go without care or, if they have access to some level of prenatal care, go without full health benefits. For example, a study of migrant and seasonal farm workers in Oregon and Washington showed that 50 percent entered a Yakima Valley Farm Workers Clinic for prenatal care in Oregon, compared with 87 percent in Washington; likewise, 19 percent of Oregon women enter prenatal care as late as the third trimester, compared with only 2 percent in Washington. Reason: Washington has long offered state-funded prenatal care statewide to women who are undocumented or who haven't yet met the residency requirement. Oregon does not.

Oregon's overall rate of women receiving prenatal care is 80 percent, compared with 84 percent nationally. In 2005, 2,633 women received inadequate prenatal care, and 2,808 low birth weight babies were born. Low birth weight infants are more likely to have disabilities, heart defects and respiratory illness and are five more times likely to die than those born at normal birth weight.

In 2002, the federal Centers for Medicare and Medicaid Services (CMS) allowed states to address the challenge of prenatal care for women who are undocumented or who are documented but haven't met the five-year residency requirement. Oregon has not yet taken full advantage of this opportunity.

This package would deliver the benefits of a successful 15-month pilot in Multnomah and Deschutes counties statewide. During a similar 15-month period, statewide services would reach an estimated 7,500 to 8,000 eligible women. Using the enhanced match rate under the State Children's Health Insurance Program, state dollars are maximized, local budgets get relief, and impoverished women who often experience high-risk pregnancies receive paid prenatal care.

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

This would aid the Department in achieving benchmarks and goals because it directly aligns with a benchmark and corresponding performance measures for increasing care for pregnant women. It also aligns

with the Department's goal that people are healthy and the department's mission to "assist people to become independent, healthy and safe" by providing crucial health care services at a critical time.

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?

- Performance measure 18 -- the percentage of low-income women who receive prenatal care in the first four months of pregnancy
- Performance measure 30 -- the proportion of racial and ethnic clients who receive health care annually
- Performance measure 31 -- the percentage of uninsured Oregonians served by safety net clinics (where many of the pregnant women in the target population receive prenatal services).

NOTE: Performance measures 30 and 31 are not tied to the Oregon Benchmarks, but to DHS High Level Outcome E, the percentage of Oregonians with access to physical health care.

- This proposal also aligns with a new key performance measure that DHS is proposing beginning with the 2009-11 biennium that measures the percentage of pregnant OHP clients who receive an adequate number of prenatal care visits while on the OHP.
- The proposal also aligns with Benchmark 40 and High Level Outcome C, the percentage of babies whose mothers received prenatal care beginning in the first trimester.

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.

No.

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

Alternatives are scarce for funding prenatal care for this population. If the state implements broader initiatives to insure more Oregonians, safety net clinics would have more flexibility to provide services to this population with funds currently earmarked to serve other uninsured patients. Relying on this possibility, however, will not ensure that prenatal care is available across the state for CAWEM clients, who are eligible only for emergency care including labor and delivery.

The alternative to providing prenatal care to only part of the population with local and “soft” funding, and *no* prenatal care to the rest of the population, is unnecessary now that the state has attained federal approval to use federal SCHIP Title XXI funds for prenatal services for the eligible population.

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

Not funding this three-element package would not only adversely affect the health of several thousand women and their infants, but also potentially be costly to the Medicaid program.

Women living between 185 percent and 200 percent of the federal poverty level would not receive coverage. Women already potentially eligible for coverage would still wait up to six weeks for eligibility determination, a six-week period critical to early prenatal care. And women now eligible only for federally mandated emergency services would receive prenatal care only as uncompensated care, if they receive it at all.

One element of prenatal care is providing women encouragement and reasons for giving up unhealthy habits such as tobacco, alcohol and illegal drugs, which harm health and whose outcomes also are costly to Medicaid.

For example, Oregon has 5,600 smoking-affected births annually at a yearly cost of \$9.5 million. In 2006, 34,727 Oregon individuals were living with fetal alcohol spectrum disorder at an annual cost of \$91 million.

That helps to explain why national studies show savings of \$1.70 to \$3.38 for every dollar invested in prenatal care. Moreover, the U.S. Department of Health and Human Services says babies born to mothers who receive no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers received prenatal care.

By not taking advantage of federal authorization to provide prenatal care to women who are undocumented or who have not met the five-year residency requirement, several thousand women and their infants lose the proven benefits of prenatal care; Oregon loses the enhanced federal Medicaid match of 74 percent; the

successes and lessons learned in the 15-month pilot in Multnomah and Deschutes counties would be lost; and safety net clinics, which are not available in all communities, would continue to be stretched to continue providing this care.

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

Local government would benefit from this POP by the infusion of federal funds to support and expand services to an underserved population.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2009 (statewide prenatal expansion) and January 1, 2010 (increase in federal poverty level and presumptive eligibility)

End Date (if applicable): ongoing

The expansion of the prenatal program can be implemented on July 1, 2009, because it is an expansion of an existing two-county pilot with no ramp-up time necessary prior to implementation. This is because systems, procedures and operations were developed and implemented for the two-county pilot that will serve to encompass the statewide program.

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

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

Administrative support will be required for minor information systems updates and maintenance as well as for document management.

The Division of Children, Adults and Families is responsible for eligibility and enrollment, training of local workers and client notices related to eligibility and enrollment.

The Division of Medical Assistance Programs is responsible for administering the program under the terms and conditions of the State Medicaid Plan and the federal SCHIP program. The Division is responsible for ensuring the provision of and payment for covered services; performing program evaluations; developing and disseminating client, provider and public communications and program management and oversight.

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 checked="" type="checkbox"/> Other (Specify below) | |

- Human Resources – Will review and approve position descriptions and will manage recruitment and hiring
- Document Management – Will image new applications
- Information Services (computers) – Will need to be able to process immediate eligibility for eligible women.
- Other -- Claims Processing – Will need to be able to process claims for services performed during presumptive eligibility period
- Other – CAF – Will have a additional new positions
- Facilities – Will manage space needs for new staff

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

Presumptive eligibility: All pregnant women, from all relevant eligibility groups will potentially be provided an additional two months of OHP ambulatory services, depending on the length of time it

takes to determine eligibility.

1. An estimated 1,295 women who will not obtain OHP eligibility but will receive the presumptive eligibility ambulatory benefit for an average of two months
2. An estimated 1,998 women who will be found eligible for OHP Coverage -- These clients would not have applied for OHP without Presumptive Eligibility and will receive an average of one month presumptive eligibility ambulatory services and an average of six months OHP services.
3. An estimated 1,678 children of Population 2 -- These children after birth receive one year of managed care or fee-for-service benefits under the OHP.
4. An estimated 15,831 women who would be OHP Clients without Presumptive Eligibility and who would receive one month of ambulatory prenatal care under Presumptive Eligibility, in addition to their full OHP benefit for an average of six months
5. An estimated 4,459 CAWEM-eligible women who will receive an ambulatory benefit for an average of two months.

Prenatal expansion of two-county pilot: There are approximately 6,000 births to CAWEM-only eligible women statewide per year, with an average growth rate of 5.5% per year. Labor and delivery care is already supported by state General Funds and federal matching funds. Under the Prenatal Expansion Program, prenatal care under the OHP Plus program (with the limitations detailed in #1 above) will also be supported by state General Funds and significantly enhanced federal matching funds.

Increase in federal poverty level to 200%: This POP will add an average of 88 women per month for 24 months for the 2009-11 biennium, to the Poverty Level Medical (PLM) program. In the 2011-13, biennium there will be an average caseload increase of an additional 164 women per month.

There will be additional women served in the Citizen-Alien Waivered Emergency Medical (CAWEM) program. This POP will add an average of 68 women per month for 24 months for the 2009-11 biennium. In 2011-13 there will be an average caseload increase of an additional 141 women per month.

This POP will increase the caseload for PLM children by an average of 31 children per month for 24 months, for the 2009-11 biennium. In the 2011-13 biennium, there will be an average caseload increase of 147 children per months for 24 months.

There will be additional children served who were born to mothers in the CAWEM program. This POP will add an average of 21 children per month for 24 months for the 2009-11 biennium. In the 2011-13 biennium, there will be an average caseload increase of 127 children.

- 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.**

Presumptive eligibility staffing needs:

DMAP

- 1 FTE limited duration position for initial provider training, Training Specialist 2, salary range 27, for 1 year
- 1 FTE Public Service Representative 3 at salary range 15 for added caseload for client hotline
- 1 FTE Medical Review Coordinator at salary range 28 for OHP Benefits/RN Review Analyst to address added caseload

CAF: 2.16 FTE Human Services Specialist 2 at salary range 17

Increase in federal poverty level to 200% staffing needs:

The increase in caseload will require an additional position in CAF. They will need .78 FTE, Human Services Specialist 2, in 2009-11. In 2011-13 they will need .75 FTE, Human Services Specialist 2. This will be a permanent position.

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

Presumptive eligibility: \$50,000 – DMAP:

- Provider training materials
- Presumptive Eligibility Applications

- Presumptive Eligibility Medical Cards
- Provider and Client Notices and outreach

Prenatal expansion of two-county pilot: DHS has already expended the start-up costs, including modifying both current and new information systems for the pilot phase of the program. The systems have all been designed to accommodate the statewide program. Materials, outreach, training, client notices, provider notices and other communications will be required, but the costs are negligible.

Increase in federal poverty level to 200%: This POP will result in a small increase in caseload for current programs making the start-up costs insignificant and will be absorbed by current DHS resources. This POP will have a nominal impact to DMAP Communications and Operations.

f. What are the ongoing costs?

Presumptive eligibility: Program costs to provide OHP Ambulatory benefits to the eligible population during the Presumptive Eligibility period, presumptive eligibility applications and presumptive eligibility medical care cards.

Prenatal expansion of two-county pilot: Program costs to provide OHP Plus benefits (with the limitations detailed in #1 above) to the eligible population during the eligibility period.

Increase in federal poverty level to 200%: The ongoing costs will be the per-member-per-month capitation rates and fee-for-service claims for the increased caseload.

g. What are the potential savings?

Presumptive eligibility: Early prenatal care will benefit both the mother and the child. The child will

be served by the OHP until at least her/his first birthday, and the mother may continue to be an OHP client as well. While it is indeterminate what the dollar amount of savings for improved infant health might be, national studies suggest that \$1.00 spent on prenatal care yields between \$1.70 and \$3.38 in savings by reducing neonatal complications. Only longitudinal studies will confirm such savings.

Savings will accrue to local government and other local partners that fund some level of early prenatal care for women who subsequently become eligible for the OHP using local and private funds. With implementation of this POP, these funds can be redirected to other pressing local health matters.

Prenatal expansion of two-county pilot: Redirecting state General Funds from funding only labor and delivery under the federal Medicaid match (estimated at 63.02% for the 2009/2011 biennium) to funding prenatal care *and* labor and delivery under the federal SCHIP program (approximately 74.11% for the 2009-11 biennium) will maximize the state's ability to leverage federal funds.

Savings will accrue to local government and other local partners that have been funding some level of prenatal care to a portion of the population using local, private and a variety of grant funds. With implementation of this POP, these funds can be redirected to other pressing local health matters. At the same time, more clients will be served with a more comprehensive package of benefits, due to the use of previously unavailable SCHIP federal matching funds.

It will also provide crucial care to benefit the unborn child which will be an "Assumed Eligible Newborn" at birth and served by the OHP until at least her/his first birthday. While it is indeterminate what the dollar amount of savings for improved infant health might be, national studies suggest that \$1.00 spent on prenatal care yields between \$1.70 and \$3.38 in savings by reducing neonatal complications. Only longitudinal studies will confirm such savings.

Significantly, the program will aid in detecting what may be a high-risk pregnancy. With early detection of high-risk pregnancies, health care providers, as well as the client, can be prepared in order to ensure that the most effective care delivered in the most appropriate setting is available for the birth, potentially avoiding more serious and expensive complications.

Increase in federal poverty level to 200%: There won't be a savings to DHS. The savings will be to the FQHCs, Community Health Centers and Safety Net Clinics and hospitals that may provide services to uninsured patients.

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."

Presumptive eligibility and increase in federal poverty level to 200%: Medicaid General and Federal Funds -- Title XIX approximately 63.02% federal dollars and 36.98% state General Fund.

Prenatal expansion of two-county pilot: Federal State Children's Health Insurance Program (SCHIP) matching funds of approximately 74.11% of total program cost; State General Funds of approximately 25.89% of total program cost