CENTERS FOR MEDICARE & MEDICAID SERVICES AMENDED WAIVER LIST AND EXPENDITURE AUTHORITY

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Department of Human Services

Medicaid mandatory and optional State plan groups described below are subject to all applicable Medicaid and CHIP laws and regulations except as expressly waived. Groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration, described as populations 9, 10, and 11, are subject to all applicable Medicaid and CHIP laws and regulations, except as expressly waived or designated as not applicable. Groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration, described as populations 12, 14, 17, and 18 are not subject to Medicaid and CHIP laws or regulations, except as specified in the Special Terms and Conditions (STCs) and waiver and expenditure authorities for this Demonstration. The Demonstration will operate under these waivers beginning November 1, 2010, and will continue through October 31, 2013, unless otherwise stated. The authority under this list is limited to the extent necessary to fulfill the objective contained in the narrative descriptions.

Populations Under OHP

The following defines the title XIX and title XXI populations under this Demonstration. The following title XIX populations are granted costs not otherwise matchable (CNOM) under Medicaid. The CHIP populations (16 and 20) are also listed below, but are not granted CNOM authority. Rather, the CHIP populations are granted specific title XXI waivers listed below.

Population 1: Medicaid mandatory pregnant women included in the State plan with incomes from 0 to 133 percent of the Federal poverty level (FPL) who are in direct State coverage (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if Family Health Insurance Assistance Program (FHIAP) is available, will be given the choice of FHIAP.)

Population 2: Medicaid optional pregnant women included in the State plan with incomes from 133 to 185 percent of the FPL (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 3: Medicaid children 0 through 5 included in the State plan with incomes from 0 to 133 percent of the FPL (as defined in the STCs). This population also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by Federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL. (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 4: Medicaid children ages 6 through 18 included in the State plan with incomes from 0 to 100 percent of the FPL (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 5: Medicaid mandatory foster care and substitute care children (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 6: Medicaid mandatory AFDC section 1931 low-income families (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 7: Medicaid mandatory elderly, blind, and disabled individuals with incomes at the SSI level of the FPL (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 8: Optional elderly, blind and disabled individuals with incomes above the Supplemental Security Income (SSI) level of the FPL (as defined in the STCs). (These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 9: General Assistance expansion individuals with incomes up to and including 43 percent of the FPL (as defined in the STCs). (These are individuals who will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)

Population 10: Expansion parents age 19 through 64 with incomes up to 100 percent of the FPL (as defined in the STCs). (These individuals will be enrolled in OHP-Standard; however, if employee-sponsored insurance (ESI) is available, these individuals will be required to enroll in FHIAP, if FHIAP is open and can extend coverage.)

Population 11: Expansion childless adults age 19 through 64 with incomes up to 100 percent of the FPL (as defined in the STCs). (These individuals will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP, if FHIAP is open and can extend coverage.)

Population 12: Participants in FHIAP with incomes up to 170 percent of the FPL as of September 30, 2002 (as defined in the STCs). (This would be the current State-funded FHIAP parents and childless adults who already have insurance, and the FHIAP children.)

Population 14: Participants who would have been eligible for Medicaid but choose FHIAP instead, with incomes from 0 to 185 percent of the FPL.

Population 16: Uninsured children ages 0 through 5 with incomes from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with incomes from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in FHIAP.

Population 17: Uninsured parents of children who are eligible for Medicaid or CHIP, who are themselves ineligible for Medicaid/Medicare with incomes from 0 up to and including 200 percent of the FPL (as defined in the STCs), who are enrolled in FHIAP.

Population 18: Uninsured childless adults who are not eligible for Medicaid/Medicare with incomes from 0 up to and including 200 percent of the FPL (as defined in the STCs) who are enrolled in FHIAP.

Population 20: Uninsured children ages 0 through 18 with incomes from above 200 percent of the FPL up to and including 300 percent of the FPL, who meet the title XXI definition of a targeted low-income child and choose voluntary enrollment in Healthy Kids ESI. (Effective January 1, 2010).

Populations 15 and 19, under prior Demonstration periods, are covered under the title XXI State plan as of November 1, 2007, and are no longer subject to this Demonstration.

Population 13: Pregnant women with incomes from 170 percent up to and including 185 percent of the FPL, under prior Demonstration periods has been combined with Population 2, which now covers all pregnant women with incomes from 133 percent up to and including 185 percent of the FPL, under the title XIX State plan.

Title XIX- Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), the following expenditures that would not otherwise be regarded as expenditures under title XIX will be regarded as expenditures under the State's title XIX plan. The following amended expenditure authorities are approved with the renewal of the Demonstration beginning November 1, 2010 through October 31, 2013:

1. Expenditures to provide services to the population that would otherwise be excluded by virtue of enrollment in managed care delivery systems that do not meet all requirements of section 1903(m) of the Act. Specifically, Oregon managed care plans will be required to meet all requirements of section 1903(m) of the Act, except the following: 1903(m)(1)(A) and (2)(A); 42 CFR 434.20 and 21, insofar as they restrict payment to a State that contracts for comprehensive services on a prepaid or other risk basis, unless such contracts are with entities that: meet Federal health maintenance organization (HMO) requirements or State HMO requirements, and allow Medicaid members to disenroll, as set forth in section 1903(m)(2)(A)(vi) of the Act. The State will lock in enrollees for the period of 6 months or more in FCHPs, PCOs, DCOs, MHOs, and PCM organizations. (Applies to all title XIX populations.)

2. Expenditures for costs that might otherwise be disallowed under section 1903(f) of the Act; 42 CFR 435.301 and 435.811, insofar as they restrict payment to a State for eligibles whose income is no more than 133⅓ of the AFDC eligibility level. (State does not presently have a medically needy program.)

3. Expenditures for costs of Medicaid to individuals who have been guaranteed 6 to 12 months of Medicaid when they were enrolled, and who ceased to be eligible for Medicaid during the 6-12-month period after enrollment. (Applies to all title XIX populations that participate in OHP-Standard and FHIAP.)

4. Expenditures for costs of chemical dependency treatment services which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner. (Applies to all title XIX populations.)

5. Expenditures for costs for capitation payments provided to managed care organizations (MCOs) which restrict enrollees' right to disenroll in the initial 90 days of enrollment in an MCO, as designated under sections 1903(m)(2)(A)(vi) and 1932(a)(4)(A) of the Act. (Applies to all title XIX populations.)

6. Expenditures for costs for certain mandatory and optional Medicaid eligibles who have elected to receive coverage through a private or ESI plan. Such enrollment in a plan that offers a limited array of services or in a private or employer-sponsored plan is voluntary and the family may elect to switch, if eligible, to direct State coverage at any time, and families will be fully informed of the implications of choosing FHIAP rather than direct State coverage. (Applies to population 14.)

7. Expenditures for health care-related costs for Demonstration Populations 9, 10, 11, 12, 14, 17, and 18.

Title XIX Waiver Authority

The following requirements are waived for all Medicaid populations, and are not applicable to populations 9, 10, and 11, beginning with the approval of this Demonstration renewal beginning November 1, 2010 through October 31, 2013.

1. Statewideness/Uniformity — Section 1902(a)(1), 42 CFR 431.50

This waiver enables the State to provide certain types of managed care plans only in certain geographical areas of the State. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the State. (Applies to all populations.)

2. Amount, Duration and Scope of Services — Section 1902(a)(10)(A), 1902(a)(10)(B), 42 CFR 440.230-250

To enable the State to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the State Plan to mandatory Medicaid eligibles, to enable the State to limit the scope of services for optional and expansion eligibles. (Applies to all title XIX populations with the exception of Population 1 and Population 3 for children 0 up to 1 year of age.)

3. Eligibility Standards — Section 1902(a)(17)

		42 CFR 435.100 and 435.602-435.823

To enable the State to waive income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming restrictions, and to base eligibility on household family unit (rather than individual income). (Applies to Populations 1, 2, 3, 4, 9, 10, 11, 12, 14, 17, and 18.

4.	Eligibility Procedures	Section 1902(a)(10)(A) and 1902(a)(34) 42 CFR 435.401 and 435.914

To enable the State to apply streamlined eligibility rules for individuals. The 3-month retroactive coverage will not apply, and income eligibility will be based only on gross income. (Applies to Populations 1, 2, 3, 4, 9, 10, 11, 12, 14, 17, and 18.)

5.	Freedom of Choice	Section 1902(a)(23) 42 CFR 431.51

To enable the State to restrict freedom-of-choice of provider by offering benefits only through managed care plans (and other insurers), and by requiring beneficiaries to enroll in managed care without a choice of managed care plans. (Applies to all populations.)

6.	Payment of Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	Section 1902(a)(10)

To enable the State to offer FQHC and RHC services only to the extent available through managed care providers. (Applies to all populations.)

7.	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Section 1902(a)(10)(A) and 1902(a)(43)(C)

To allow the State to restrict coverage of services required to treat a condition identified during an EPSDT screening to the extent that the services are beyond the scope of the benefit package available to the individual. The State must arrange for, and make available, all services within the scope of the benefit package available to the individual that are required for treatment of conditions identified as part of an EPSDT screening. (Applies to Populations 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 17, and 18.)

8.	Disproportionate Share Hospital (DSH) Reimbursements	Section 1902(a)(13)(A)

To allow the State to not pay DSH payments when hospital services are furnished through managed care entities. (Applies to all title XIX populations.)

9.	Prepaid Ambulatory Health Plan Enrollment	Section 1902(a)(4) as implemented in 42 CFR 438.56(c)

To enable Prepaid Ambulatory Health Plans to permit enrollees a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all populations.)

10.	Reasonable Promptness	Section 1902(a)(8) 42 CFR 435.906, 435.911, 435.914, and 435.930(a)

To permit the State to implement a reservation list as a tool to manage enrollment in OHP-Standard and FHIAP. (Applies to Populations 10, 11, 12, 14, 17, and 18.)

Title XXI Waivers

All requirements of the CHIP program expressed in law, regulation, and policy statement, not expressly waived or identified as *not applicable* in this list, shall apply to the Demonstration project under title XXI of the Act beginning November 1, 2010 through October 31, 2013. In addition, these waivers may only be implemented consistent with the approved STCs. These waivers apply to Demonstration Populations 16 and 20.

1. Benefit Package Requirements **Section 2103**

To permit the State to offer a benefit package for Demonstration Populations 16 and 20 that does not meet the requirements of section 2103 of the Act, as defined in Federal regulations at 42 CFR 457.410(b).

2. Cost Sharing **Section 2103(e)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to Demonstration Populations 16 and 20 to the extent necessary to enable the State to impose cost sharing in private or ESI plans.

Summary Chart of Demonstration Populations

I. Mandatory Medicaid Populations*							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
1	Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL	None	OHP Plus	Base 1
3	Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL**	None	OHP Plus	Base 1
4	Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0% up to 100% FPL	None	OHP Plus	Base 1
5	Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	Base 2
6	AFDC low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	Base 2

II. Optional Medicaid Populations***							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
8	Aged, Blind, & Disabled	Title XIX	Section 1115 and Title XIX State Plan	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus	Base 2

2	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	133% up to 185% FPL	None	OHP Plus	Base 1

III. Expansion Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
9	General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus	Expansion
10	Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard	Expansion
11	Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard	Expansion

IV. Optional and Expansion Medicaid /CHIP Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
12	Participants in FHIAP as of 9/30/02; prior State-funded FHIAP parents and childless adults who already have insurance; FHIAP children	Title XIX	Section 1115	Up to 170% FPL	None	FHIAP	Expansion
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
14	Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	0 up to 185% FPL	None	FHIAP	Expansion

16	Uninsured targeted low income children ages 0 through 5, and Uninsured targeted low income children ages 6 through 18 These children choose voluntary enrollment in FHIAP.	Title XXI	Section 1115 and Title XXI CHIP State Plan	133 up to and including 200% FPL 100 up to and including 200% FPL	None	FHIAP, including well-baby, well-child, immunizat-ions and emergen-cy services.	Optional
17	Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	0 up to and including 200% FPL	None	FHIAP	Expansion
18	Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	0 up to and including 200% FPL	None	FHIAP	Expansion

Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
20	Uninsured targeted low income children ages 0 through 18 who choose voluntary enrollment in Healthy Kids ESI	Title XXI	Section 1115 and Title XXI CHIP State Plan	Above 200% up to and including 300% FPL	None	Healthy Kids ESI child only premium assistance, including well-baby, well-child, immunizat-ions, and emergency services.	Optional

* Mandatory populations have the option of choosing FHIAP, in which case they would be in Population 14.

**Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the State also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by Federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.

***Optional Medicaid (OHP Plus) populations have the option of choosing FHIAP, in which case they would be in Population 14.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan 2

AWARDEE: Oregon Department of Human Services

DEMONSTRATION EXTENSION PERIOD: November 1, 2010, through October 31, 2013

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115 (a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to this agreement are the Oregon Department of Human Services (State) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. These STCs are effective November 1, 2010, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through October 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Prioritized List; Benefits; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements for Title XIX; General Financial Requirements for Title XXI; and Monitoring Budget Neutrality for the Demonstration.

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan is a continuation of the State's Demonstration, funded through titles XIX and XXI of the Social Security Act. Oregon Health Plan is an 1115(a) Demonstration that began in phases on February 1994. Phase I of the Medicaid Demonstration Project started on February 1, 1994 for Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II brought additional populations into the OHP: the aged, blind, disabled, and children in State custody/foster-care. Following the creation of Title XXI of the Social Security Act by Congress in 1997, Oregon's Children's Health Insurance Program (CHIP) was incorporated into the Oregon Health Plan. From its inception, Oregon's CHIP provided eligibles with essentially the same benefit package available to all OHP-Medicaid clients, as well as a seamless delivery system.

In October 2002, CMS approved Oregon's application to amend its Medicaid Demonstration project under Section 1115 of the Social Security Act and to implement a new Health Insurance

Flexibility and Accountability (HIFA) Demonstration. With this approval, Oregon was able to expand the Demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

In the extension beginning November 1, 2007, the structure of the populations within the Demonstrations is changed to reflect updated CMS policy. Uninsured adults not eligible for Medicaid or CHIP are removed from the title XXI expansion populations and are moved into title XIX expansion populations. In addition, title XXI targeted low-income children (TLIC) in Oregon from ages 0 through 5 years with incomes from 133 percent to 185 percent of the FPL and ages 6 through 18 with incomes from 100 percent up to 185 percent of FPL, will receive eligibility under the CHIP state plan regardless of whether the child opts for CHIP direct state plan coverage (OHP Plus) or premium assistance (Family Health Insurance Assistance Program/FHIAP). Once a child opts for premium assistance, the child will receive authority strictly under this Section 1115 demonstration and not be subject to title XXI State plan rules that are explicitly waived under the demonstration. However, title XXI children who choose premium assistance can opt into direct state plan coverage at any time. In addition, it is clarified that mandatory pregnant women and children 0 to 1 year of age are required to receive full Medicaid State Plan benefits, subject to necessary pre-authorizations.

Under this Demonstration, Oregon expects to achieve the following to promote the objectives of title XIX and title XXI:

- Health care coverage for uninsured Oregonians
- A basic benefit package of effective services
- Broad participation by health care providers
- Decreases in cost-shifting and charity care
- A rational process for making decisions about provision of health care for Oregonians
- Control over health care costs

Two unique features of the Oregon Demonstration are:

- It makes Medicaid available to people living in poverty regardless of age, disability or family status.
- It structures benefits (what is covered), using a prioritized list of health care conditions and treatments. This approach enables Oregon to sharply focus its resources towards prevention, and also utilize funding lines as a method of controlling costs.

On July 28, 2009 the State submitted a Demonstration amendment request to CMS under its "Healthy Kids," initiative. Created by House Bill 2116 during Oregon's 2009 Legislative Session, Healthy Kids provides coverage for uninsured children through age 18 in the State. The objective of Healthy Kids is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. The State is proposing an eligibility increase from 185 percent of FPL up to and including 300 percent of FPL for children. The State will also provide access to coverage for children above 300 percent of FPL, but will not receive FFP for this population. Healthy Kids includes three different program components: 1) Existing CHIP direct coverage (OHP Plus), 2) Child only premium assistance administered by the Office of Private Health Partnerships, and 3) A new private insurance component (Healthy KidsConnect*)* that will be offered under the CHIP State Plan. The Federal

government will provide match for children up to and including 300 percent of the FPL in the demonstration, (populations 16 and 20), as well as those under the CHIP State Plan. Through Healthy Kids, children up to and including 200 percent of the FPL have the choice between title XXI state plan coverage or premium assistance through FHIAP, or Healthy Kids ESI. Children above 200 percent of FPL up to and including 300 percent of the FPL have the choice between child only premium assistance through Healthy Kids ESI, or coverage under the CHIP state plan in Healthy KidsConnect.

In addition, the State is requesting to expand coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 185 percent of FPL up to and including 200 percent of FPL.

On August 12, 2009 the State submitted a Demonstration amendment request to CMS to change the methodology for use of a 'reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program.

On August 21, 2009 the State submitted a Demonstration amendment request to CMS to limit OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

On October 8, 2009 the State requested to amend the Demonstration after completion of a biennial review of the List of Prioritized Services. The State offers OHP benefits based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services, which is determined by the State appointed Health Services Commission and public input. The 2010-2011 List of Prioritized Services in nearly identical to the current 2008-2009 list. The 2010-2011 list places a new emphasis on preventive care and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crises stages of a disease.

On October 22, 2009 the State of Oregon submitted its application and its formal request to the Centers for Medicare and Medicaid Services (CMS) requesting an extension of the State's section 1115(a) Medicaid demonstration, known as the Oregon Health Plan (OHP).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, reservation list, sources of non-Federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include

current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request Demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives: The State must provide a narrative summary of the Demonstration project, reiterate the objectives set forth at the time the Demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   c. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

   d. Quality: The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO); State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the Demonstration.

   e. Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate,

historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the Demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the Demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan shall not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation during Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid or CHIP under the current State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a

hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6 are proposed by the State.

16. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

17. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the State for premiums paid by beneficiaries shall not be used as a source of State match for FFP.

IV. THE OREGON HEALTH PLAN

18. The Oregon Health Plan (OHP). OHP provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Programs (DMAP).

a. **Eligible Populations**. Within OHP, the State will provide health insurance coverage to Oregonians who have applied for and who have been determined eligible for the OHP programs defined within these special terms and conditions (STCs). This includes:

   i. Specified Medicaid mandatory and optional groups under the Oregon State plans, as well as specified expansion groups included under this Demonstration.
   ii. Medicaid State plan and optional groups are served in OHP Plus, or FHIAP if it is available; and the CHIP optional group is served in FHIAP.
   iii. Expansion adult populations are provided with OHP standard benefits, or FHIAP if available and these programs provide benefit packages, as described under the benefits section of these STCs. The mandatory and optional Medicaid State plan populations described below derive their eligibility through the Medicaid State plan and are subject to all applicable laws and regulations in accordance with the Medicaid State plan, except as expressly waived and as described in these STC's.

b. **Savings** are generated to fund the expansion populations by structuring benefits using a prioritized list of health services, by mandatory managed care enrollment (waiving the freedom of choice requirement), and by waiving other specific programmatic requirements. These populations are considered under budget neutrality for both the "with waiver" and "without waiver" computations.

c. **Applicability.** Medicaid mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration.

d. **Screening for Medicaid, CHIP and other Health Insurance Products for Children**. Children (population 16, and 20) obtaining health insurance coverage as a result of participation in this Demonstration will be screened for Medicaid and CHIP eligibility at initial application under Healthy Kids, at least every 12 months, and prior to enrollment in FHIAP. Applicants will be offered an informed choice of voluntary enrollment in direct coverage under the Medicaid or CHIP program depending on the program for which they may be eligible. Should a child opt to enroll in premium assistance under FHIAP, or Healthy Kids ESI, and subsequently disenroll from any of these programs, eligible children will be notified of their potential eligibility in Medicaid or CHIP.

   Enrollment in FHIAP is required if ESI is available for individuals eligible for OHP Standard (populations 10 and 11).

e. **OHP Benefits.** The Oregon Health Plan Demonstration has four components, two offered directly through public sector programs (OHP Plus and OHP Standard) and two through a combination of public and private sector funds (premium assistance under FHIAP and premium assistance for children only under Healthy Kids ESI). Most beneficiaries under the OHP Demonstration receive services through managed care delivery systems.
   i. All mandatory Medicaid State Plan eligibles are covered under Oregon's coverage receive their Medicaid services through the OHP Plus benefit State Plan (populations 1, 3, 4, 5, 6 and 7). Those with OHP direct public coverage receive the OHP Plus benefit package, administered by Oregon Department of Human Services (DHS). In addition, certain Optional and Demonstration Medicaid populations, including pregnant women up to 185 percent of the FPL, receive coverage under OHP Plus (populations 8, 2 and 9).
   ii. The Demonstration only eligible adults ("New Eligibles") enrolled in OHP Standard receive benefits only under Oregon's Medicaid Waiver (populations 10 and 11). These eligible adults consist of parents and adults without children in the home (over the age of 18).
   iii. All mandatory and optional Medicaid State Plan eligible children younger than 21years old enrolled in Medicaid are entitled to receive all State Plan and EPSDT covered services (populations 3, 4, 5, 6 7, and 8).
   iv. FHIAP is Oregon's premium assistance program. Through FHIAP, eligible uninsured Oregonians (adults and children) can receive premium subsidies for the purchase of private health insurance both individual and employer-sponsored insurance (populations 12, 14, 16, 17 and 18). Both adults and children applying for coverage through FHIAP are subject to the FHIAP reservation list.
   v. Children only in families with incomes from zero up to and including 200 percent of the FPL (Population 16) can also receive premium assistance through

Healthy Kids ESI if available and voluntarily chosen by the family. These children apply for coverage through DHS and are not subject to the FHIAP reservation list.

vi. Children only in families with incomes above 200 up to and including 300 percent of the FPL can also receive premium assistance through Healthy Kids ESI if available and chosen by the family (population 20) and coverage under the CHIP State plan in Healthy KidsConnect.

vii. Medicaid Services and Expenditures Not Included in the OHP Demonstration
   a) Mental Health Facility – DSH Adjustment Payments
   b) Long Term Care Services
      1. Nursing Facility Services
      2. Home- and Community-Based Services
      3. Community Supported Living Services
      4. Programs of All-Inclusive Care Elderly
   c) ICF/MR Services
   d) Medicare Premium Payments
   e) Personal Care Services
   f) Targeted Case Management Services

f. **Benefits and the Prioritized List.** The State offers OHP benefits based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services, which is determined by the State appointed Health Services Commission and public input.

i. **Health Services Commission**. The Commission consists of eleven members appointed by the Governor, and includes five physicians, four health consumers, one social worker and one public health nurse. The Health Services Commission performs a biennial review of the prioritized list and will amend the list as required.

ii. **Modifications to the Prioritized List**. Modifications to the Prioritized List require Federal approval through submission of an amendment, as described in paragraph 7 and 18 (h), in order to ensure the list is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized list of health services is maintained by the State of Oregon at the website below: http://www.oregon.gov/DHS/healthplan/data_pubs/main.shtml.

iii. **Use of the Prioritized List and Benefit Packages**. The Oregon Health Plan works with the Prioritized List of Health Services and is the basis for the benefit packages used in the direct coverage portion of OHP Medicaid and CHIP. The OHP clients receive benefits based on where health care conditions and treatments are placed on the Prioritized List of Health Services.

iv. **Ordering of the Prioritized List**. This list is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those

services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).

v. **Updating the Prioritized List**. The Commission is charged with updating the list for every biennial legislative session. The Oregon State Legislature determines how much of the list to cover (subject to Federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.

vi. **Non-covered Condition and Treatment Pairs**. In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The State must adopt policies that will ensure that before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition; providers will be required to determine whether the individual has a funded condition that would require access to treatment under the program. In the case of a health care service that is not on the prioritized list of health services or an unfunded condition and treatment pair in association with a co-morbidity, where the expected outcome is comparable to that of a funded condition and treatment pair, providers will be instructed to provide the specified treatment. The State shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

g. **Funding Line on the Prioritized List.**

i. The 2008-2009 Prioritized List of Health Care Services contains 680 lines. For the purposes of the Demonstration, lines 1-503 are funded to provide benefits to the OHP Plus and Standard populations

ii. Beginning January 1, 2010, the 2010-2011 Prioritized List of Health Care Services contains 680 lines. For the purposes of the Demonstration, lines 1-502 are funded to provide benefits to the OHP Plus and Standard populations.

h. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

i. For a legislatively directed line change to reduce or increase benefit coverage or a legislatively approved biennial list with substantive benefit reduction or increase, an amendment request (in compliance with paragraph 7) and consideration by the CMS medical review staff.

ii. For interim modifications and technical changes to the list as a result of new and revised national codes and new technology, CMS notification only.

iii. For a change to the list not defined above that meets the terms of paragraph 6, an amendment request.

j. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The State will inform its provider community that it is exempt only from covering health services below the funding line, and not from any other requirements under the EPSDT program. The State is required to pay for services to treat a condition identified during an EPSDT screening that is within the scope of the benefit package available to the individual. The State must make care available to all individuals under Title XIX if that care would be for treatment of a condition covered on the Prioritized List. The State must arrange for the corrective treatment of conditions identified as part of an EPSDT screening if such conditions are covered on the Prioritized List.

k. **CHIP Program:** The CHIP program in Oregon is a separate program from Medicaid. Under the State's new Healthy Kids initiative, there are three different program components for title XXI children: 1) Existing coverage under the CHIP State plan (OHP Plus), 2) Child only premium assistance (Healthy Kids ESI) administered by the Office of Private Health Partnerships under the demonstration, and 3) A new option, referred to as Healthy KidsConnect, also offered under the CHIP State Plan. CHIP-eligible children that select coverage under the CHIP State plan are governed by the title XXI state plan and subject to all title XXI laws and regulations in accordance with the title XXI State plan. Children that select premium assistance under FHIAP or Healthy Kids ESI premium assistance under this demonstration are subject to all title XXI laws and regulations in accordance with the State plan, except as expressly waived, described as non applicable, or specified in these STCs. Children up to and including 200 percent of the FPL have the choice between title XXI state plan coverage, or coverage through Healthy Kids ESI. Children above 200 up to and including 300 percent of the FPL have the choice between child-only premium assistance under Healthy Kids ESI, or coverage under the CHIP state plan under Healthy KidsConnect.

19. Oregon Health Plan Standard (OHP Standard)

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
10	Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard	Expansion
11	Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard	Expansion

a. **Eligibility and Enrollment.** The OHP Standard benefit package is provided to uninsured parents and childless adults over the age of 18 (Populations 10 and 11, respectively). These individuals are only eligible for benefits by virtue of Oregon's Section 1115 Medicaid Demonstration.

i. **Screening and Enrollment.** Parents and childless adults who are found eligible for OHP Standard (populations 10 and 11) and have employer-sponsored insurance available are *required* to pursue eligibility under FHIAP.

a) If a parent or childless adult is found eligible for FHIAP, OHP Standard eligibility ends. (The parent or childless adult would then be eligible as defined in Populations 17 and 18, respectively).
b) If a parent or childless adult is found ineligible for FHIAP. The uninsured parent or childless adult will be enrolled in OHP Standard if enrollment availability /slots are available within the program.

ii. **Reservation List**. The State may employ a reservation list as a method of adding clients to the OHP Standard program. (Applies to populations 10 and 11).

a) Applications for OHP Standard will be provided to potential clients based on the projected budget limitations of the OHP Standard program.
b) The State may impose an enrollment cap upon the OHP Standard program in order to remain under the budget neutrality limit or to address projected budgetary limitations of the OHP Standard program. The State will be required to provide written notice to CMS at least 60 days prior to changing the budget-driven ceiling.
c) The State will be required to provide written notice to CMS at least 60 days prior to instituting any enrollment cap/ceiling or re-establishing program enrollment. The notice to CMS, at a minimum, must include:
    i. Data on current enrollment levels in the program
    ii. An analysis of the current budget neutrality agreement; and
    iii. The projected timeframe for the enrollment cap to be in effect or the period for enrollment into OHP Standard.

iii. **Managing enrollment and revising the Reservation List.**

a) For the population described in paragraph 19.a. the State may employ additional caseload management strategies to include: lowering the FPL used to determine eligibility; and/or suspending eligibility and/or intake into the program; or discontinuing coverage. No later than 60 days prior to the date of implementation, the State shall submit its plan to CMS. CMS shall complete a review of the plan for implementation and notify the State of a decision within 60 days of receiving the State's plan.

b) Beginning with the December 1, 2009 approval of this amendment to the Demonstration, the State will begin to use a new reservation list.

c) The State will perform targeted outreach to those individuals on the existing (2008) reservation list to afford those individuals the opportunity to sign up for the new reservation list if they are still seeking coverage. Outreach materials will remind individuals they can apply for OHP Plus programs at any time.

d) Periodically, the State will send notices to those individuals on the reservation list, at a minimum of every 12 months asking if they want to remain on the reservation list. If so, these individuals will be given a chance to update their contact information. These notices will remind individuals that they can apply for OHP Plus programs at any time. These notices should be a vehicle for ensuring the OHP Standard reservation list is populated with individuals who are still seeking coverage. Based on the State's budgetary constraints, DHS will periodically select individuals from the reservation list, using a randomized sampling methodology. The State will:

1) Send applications to selected individuals.
2) Determine eligibility for the selected individuals who submit applications

iv. Eligibility Redeterminations. Parents and childless adults over the age of 18 (Populations 10 and 11, respectively) enrolled in the OHP Standard program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any open OHP program. An enrollee may apply for any open OHP program at any time for any reason. The State will determine eligibility and enroll individuals in programs for which they are found eligible.

b. **Disenrollment.** Enrollees in OHP Standard may be disenrolled if they:
   i. Are approved for and seeking enrollment in FHIAP or become eligible for OHP Plus;
   ii. Exceed income limits allowed for the program at redetermination;
   iii. Exceed resource limits allowed for the program at redetermination;
   iv. Voluntarily withdraw from the program;
   v. No longer reside in the State of Oregon;
   vi. Become incarcerated or are institutionalized in an IMD;
   vii. Obtain health insurance;
   viii. Attain age 65; or
   ix. Are no longer living.

c. **The OHP Standard benefit package** consists of a core set of fixed services and other add-on services, which are dependent on available State funds. The complete set of covered services is overlaid by the Prioritized List of Health Care Services. The OHP Standard benefit package consists of the following core set of fixed services: physician services; ambulance; prescription drugs; laboratory and x-ray services; medical supplies; outpatient chemical dependency services; and emergency dental services. In addition to this fixed set of core services, OHP Standard also includes a limited inpatient hospital benefit and a hospice benefit as add-on services.

d. **Any reduction to the OHP Standard benefit package** below the core set of fixed services shall be submitted to CMS as an amendment request. Any increase in the OHP Standard benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in section IX.

Any increases to the approved OHP Standard core set of services shall not include abortion or Death with Dignity services.

Benefit Table for OHP Standard

COVERED SERVICES	OHP STANDARD
Acupuncture	Limited
Chemical Dependency Services	✓
Dental	Limited
Emergency/urgent hospital services	✓
Hearing aids and hearing aid exams	n/a
Home Health	n/a
Hospice Care	✓
Hospital Care	Limited
Immunizations	✓
Labor and Delivery	✓
Laboratory and X-ray	✓
Medical Equipment and Supplies	Limited
Medical Transportation	Limited
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	n/a
Physician Services	✓
Prescription Drugs	✓
Private Duty Nursing	n/a
Vision	Limited

e. Cost Sharing under OHP Standard

i. OHP Standard co-payments were discontinued on June 19, 2004.
ii. However, some OHP Standard clients pay premiums.
iii. For those who are required to pay premiums, the premium charge is between $9-20 a month.
iv. The State is permitted to require clients to be current on their premium payments to reapply for another 6-month eligibility period.
v. OHP Standard clients with household income 10 percent or less of the Federal poverty level at the time of enrollment do not pay premiums.
vi. Any increase in premiums or cost-sharing must be submitted to CMS for notification purposes and approval as a Demonstration amendment as per paragraph 7.

20. Oregon Health Plan Plus (OHP Plus)

a. **Eligibility -** Medicaid State plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8 and 9) are served in the component known as OHP Plus.

i. Mandatory populations (populations 1, 3, 4, 5, 6, and 7) have the option of choosing FHIAP in which case they would be in Population 14.
ii. Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the State also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by Federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.
iii. Optional Medicaid/CHIP populations (2, and 8) have the option of choosing FHIAP, in which case they would be in Populations (14, 16 or 20).

b. **Eligibility Redeterminations.** Medicaid State plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, and 9) enrolled in the OHP Plus program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any OHP program. Any enrollee may apply for any OHP program at any time for any reason. The State will determine eligibility and enroll individuals in programs for which they are found eligible. An enrollee found at redetermination to be ineligible on the basis of income for OHP Plus but eligible for OHP Standard will be transferred to OHP standard with no interruption in coverage.

Demonstration Population #	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
1	Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL	None	OHP Plus	Base 1
2	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	133% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL**	None	OHP Plus	Base 1
4	Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0% up to 100% FPL	None	OHP Plus	Base 1
5	Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	Base 2
6	AFDC low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	Base 2
8	Aged, Blind, & Disabled	Title XIX	Section 1115 and Title XIX State Plan	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus	Base 2
9	General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus	

* Mandatory populations have the option of choosing FHIAP in which case they would be in Population 14.
**Although Population 3 reflects mandatory coverage for children up to 133% of the FPL, the State also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185% of the FPL, as required by Federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185% of the FPL.
***Optional Medicaid (OHP Plus) populations have the option of choosing FHIAP in which case they would be in Population 14.

c. **Benefit**. The OHP Plus benefit package is the Prioritized List of Heath Care Services through the line on the list funded by the Oregon State Legislature.
   i. The benefits table in paragraph 20(d) provides a high-level summary of the services funded and covered on the prioritized list.

ii. OHP Plus is the Medicaid State Plan Services Benefit Package for Mandatory pregnant women and children 0 up to 1 year of age (populations 1 and 3, respectively), subject to necessary pre-authorization.

d. **Benefits Table for OHP Plus**

COVERED SERVICES	OHP PLUS[1]
Acupuncture	✓
Chemical Dependency Services	✓
Dental	Limited**
Emergency/urgent hospital services	✓
Hearing aids and hearing aid exams	✓
Home Health	✓
Hospice Care	✓
Hospital Care	✓
Immunizations	✓
Labor and Delivery	✓
Laboratory and X-ray	✓
Medical Equipment and Supplies	✓
Medical Transportation	✓
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	✓
Physician Services	✓
Prescription Drugs	✓ *
Private Duty Nursing	✓
Vision	Limited***

* For individuals with Medicare Part D, the OHP Plus benefit package does not cover drugs covered by Medicare Part D.
** **Limited Dental coverage for non-pregnant OHP Plus adults** – Effective January 1, 2010 the State will limit dental coverage for non-pregnant OHP Plus adults who are age 21 and older. Adult clients will be eligible for diagnosis, prevention, and restorations, but will no longer receive some more advanced restorative or treatment services, such as permanent crowns and endodontics on molars and on advanced procedures, such as full sets of dentures and denture adjustments, repairs and relines.
***Limited Vision coverage for OHP Plus non-pregnant adults** – Effective January 1, 2010 the State will eliminate routine vision coverage for all OHP Plus adults age 21 and older, with the exception of pregnant women. Services eliminated would include routine examinations, glasses, eye examinations for the purpose of prescribing glasses or contact lenses and fitting fees. Exceptions to the above limitation would be:

i. DMAP would pay for the above vision services for clients age 21 and older if the client had pseudoaphakia, aphakia, congenital aphakia, or keratoconus.
ii. Corrective lenses would be covered to restore vision normally provided by the natural lenses of the eye, if a person lacked organic lens due to surgical removal or congenital absence (cataracts).

[1] No benefit limitations apply to children under the age of 19 with Medicaid or CHIP direct coverage.

e. **Cost Sharing under OHP Plus.**

i. For OHP Plus, Oregon charges nominal copayments. Co-payments are not charged of enrollees who are pregnant women or children under the age of 19.
ii. The approved copayments are included in the Title XIX State Plan.
iii. Oregon uses the State Plan Amendment process to make changes to its OHP Plus copayment policies.
iv. There are no premiums for OHP Plus enrollees.

f. **Disenrollment from OHP Plus.** Enrollees in OHP Plus may be disenrolled if they:

i. Are approved for and seeking enrollment in FHIAP;
ii. Exceed income limits allowed for the program at redetermination;
iii. Exceed resource limits allowed for the program at redetermination
iv. Voluntarily withdraw from the program;
v. No longer reside in the State of Oregon;
vi. Become incarcerated or are institutionalized in an IMD;
vii. Are no longer pregnant
viii. No longer have a qualifying disability; or
ix. Are no longer living.

21. Premium Assistance

a. Overview of Premium Assistance Options

i. **Family Health Insurance Assistance Program (FHIAP) (populations 12, 14, 16, 17, and 18).** The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA), administers FHIAP. This premium assistance program provides subsidies to help families and individuals up to and including 200 percent of the FPL, including children and adults, pay for health insurance offered either through employer-sponsored insurance (ESI), or private health insurance carriers that provide coverage in the individual market.

ii. **Healthy Kids Employer Sponsored Insurance (ESI) (Population 20).** OPHP, OHA, also administers Healthy Kids ESI. As part of the July 28, 2009 amendment, Healthy Kids ESI provides child only premium assistance for children in families above 200 up to and including 300 percent of the FPL, who voluntarily enroll in the program.

b. Eligibility

i. **FHIAP.** Premium assistance for children, adults and families from zero through 200 percent of the FPL who choose voluntary enrollment in FHIAP (populations 12, 14, 16, 17, and 18). Subsidies can be used for employer-sponsored insurance (ESI) or individual health insurance. Eligible participants include:
   a) Families (including parents);
   b) Childless adults; and
   c) Children (populations 14 and 16) in families with parents who apply for premium assistance directly through the FHIAP reservation list.

ii. **Healthy Kids ESI.** Healthy Kids ESI provides child only premium assistance for families above 200 percent up to and including 300 percent of the FPL who

voluntarily enroll in ESI. 1) *Premium Assistance for* Medicaid and CHIP children in families from zero up to and including 200 percent of the FPL (populations 12, 14 and 16). These children apply for coverage through DHS and voluntarily choose to receive subsidies for ESI. Children in this income group also have the option of Medicaid or CHIP State plan direct coverage. 2) *Child Only Premium Assistance through ESI* for *children in families above 200 percent of the FPL up to and including 300 percent of the FPL (population 20)* These children apply for subsidies through DHS, have ESI available, and choose voluntary enrollment in ESI. Children in this income group also have the option of electing coverage under the CHIP State plan through Healthy KidsConnect.

c. Enrollment for Children

i. FHIAP

a) **Enrollment through FHIAP Reservation List Process.** Children from zero up to and including 200 percent FPL may receive premium assistance for individual health insurance or ESI (populations 14 and 16). These children can apply for subsidies through the FHIAP reservation list process. OPHP determines eligibility, enrolls them and pays subsidies. Children receive a 100 percent subsidy.

b) **Enrollment through Healthy Kids Application Process.** These children are also eligible for direct coverage by applying for Healthy Kids through DHS. At the time they request a FHIAP application and are put on the reservation list, families are provided with information about direct coverage through Healthy Kids, including the differences between Healthy Kids direct coverage and FHIAP benefits, cost-sharing and other provisions. They are also provided a Healthy Kids application and are encouraged to apply for immediate coverage rather than wait on the FHIAP reservation list. Families must either complete the application or actively decline coverage. These children can switch between direct coverage and FHIAP at any time.

ii. Healthy Kids ESI

a) **Enrollment for children in families from zero up to and including 200 percent FPL.** These children have the choice between CHIP direct coverage and premium assistance. These children apply for coverage through DHS and must be informed about the difference in benefits, cost sharing and other provisions between direct coverage and Healthy Kids ESI and be provided with the choice to enroll in CHIP state plan direct coverage at any time. Subsidies are paid at 100 percent for children through age 18. If a child is determined eligible and the family chooses ESI, DHS refers the child to OPHP for enrollment and subsidy payment.

b) **Children in families above 200 percent up to and including 300 percent FPL.** These children have the choice between premium assistance and direct subsidies under the CHIP State Plan through Healthy KidsConnect. These children are not subject to the FHIAP reservation list. These children apply for coverage through DHS and if found eligible the child is

referred to OPHP for enrollment and subsidy payment. Subsidies are paid for children through age 18 on a sliding scale based on family income. These children must also be informed of the differences in benefits, cost sharing and other provisions between Healthy Kids ESI and coverage under the CHIP State plan through Healthy KidsConnect. These children can switch between these two options at any time.

d. Cost Effectiveness for Children and Adults

i. **FHIAP and Healthy Kids ESI**. Oregon compares the aggregate per member per month subsidy costs for Demonstration Populations 12, 14, 16, 17 and 18 in FHIAP relative to DHS direct coverage costs for Demonstration Populations 1 through 11.

e. **Enrollment for Adults**

i. **FHIAP.** Parents and childless adults from zero up to and including 200 percent FPL (populations 14, 17 and 18) apply for premium assistance through FHIAP by first getting on a FHIAP reservation list. As program openings occur, applications are mailed to families on the list on a first come first served basis. Subsidies can be used for ESI or individual health insurance. Adult subsidies are paid on a sliding scale based on income.

f. **Enrollee Education and Notification**

i. **Adults.** Parents and childless adults eligible for OHP Plus benefits (population 14) must be periodically notified that they may choose direct coverage at any time. The State will provide information prior to enrollment in FHIAP explaining the differences in benefits, cost sharing and other provisions between State plan direct coverage and private insurance options.

ii. **Children.** Families with children from zero up to and including 200 percent FPL (populations 14 and 16) applying for FHIAP will receive written information explaining the differences in benefits, cost sharing and other provisions between Title XXI direct state plan coverage and private insurance options. Children will also be screened for Medicaid and CHIP eligibility prior to actual enrollment in FHIAP and enrolled in the appropriate program if the family selects Medicaid or CHIP state plan direct coverage.

Families with children above 200 up to and including 300 percent of the FPL are eligible for Healthy Kids ESI and under the CHIP State plan under the Healthy KidsConnect program. These families can also contact choice counselors who can help explain their insurance options.

iii. **Application Assistance.** Subject to available funding, the State will provide community-based assistance to potential applicants for Healthy Kids programs, including Healthy Kids ESI and Healthy KidsConnect, in completing and submitting their application in a timely manner.

iv. **Children and Immunization.** In the case of children, families are to be informed that coverage for all age-appropriate immunizations (in accordance with the recommendations of the Advisory Committee on Immunization Practices [ACIP]) for Title XXI eligible children are covered. Families will also be told that this coverage is a factor to consider in choosing private health insurance or ESI. The

State shall provide information as to where children may receive immunizations and well-baby and well-child services and emergency services in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled.

v. **Provider Reimbursement for Immunizations.** In the case of Title XXI eligible participants, the State must have a mechanism in place to reimburse providers for the cost of immunizations, well-baby and well-child services and emergency services so that families will not be held responsible for the costs associated with these services.

vi. **Dental Services for Children Enrolled in Premium Assistance**. Subject to legislative approval, the State will implement a program to provide dental benefits to children enrolled in FHIAP or Healthy Kids ESI either through the benchmark or as a wrap around benefit no later than January 1, 2012.

vii. **Period of Uninsurance.** As used in the tables below, the term "uninsured" means an individual who is not covered by creditable private health insurance as defined in 45 CFR 146.113 for a specified period. OHP coverage is not considered insurance in determining FHIAP eligibility. In addition, individuals with FHIAP coverage or those on the FHIAP reservation list who have met the required period of uninsurance but have since obtained coverage are exempt from the uninsurance period in determining OHP Standard or CHIP eligibility.
The following are FHIAP exceptions to the period of uninsurance. The member:

a) Is currently enrolled in the OHP;
b) Was enrolled in the OHP within the last 120 days;
c) Is a former FHIAP member;
d) Has enrolled in a creditable health insurance plan while on the reservation list.
    1. Must have met the two-month period of uninsurance immediately prior to enrolling in the creditable health insurance plan;
e) Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700 - 735.714;
f) Has a military health insurance plan;
g) Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list;
    1. Must have been without any creditable health insurance coverage for two consecutive months immediately prior to becoming insured under the group plan.
h) Has recently become unemployed and lost health insurance coverage as a result; or
i) Has lost health insurance coverage while still employed (e.g. reduction in hours, employer stops providing coverage, etc)

viii. The State must establish and maintain procedures that will:
    a) Ensure that children who enroll in ESI are enrolled in creditable coverage;
    b) Ensure the consent of the responsible adult family member to receiving premium assistance under FHIAP instead of coverage through Medicaid or CHIP;
    c) Allow Medicaid or CHIP eligible participants to opt out of FHIAP and receive direct coverage at any time, with the exception of Medicaid eligible

participants who would otherwise qualify for OHP Standard. OHP Standard direct coverage is governed by the reservation list. In addition, OHP Standard eligible participants with ESI would not be able to opt out of FHIAP and into direct coverage;

d) Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI coverage (if appropriate) and the individual's/family's share of the premium is being paid;
e) Require eligible participants to immediately notify the State if they change their ESI plan or their ESI coverage is terminated (if appropriate);
f) Ensure that the total amount of FHIAP subsidies provided to an individual or family does not exceed the amount of the employee's financial obligation toward their ESI coverage (if appropriate);
g) Provide for recovery of payments made for months in which the individual or family did not receive ESI coverage; and
h) Provide for a redetermination of eligibility at least once every 12 months.

Demonstration Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
12	Participants in FHIAP as of 9/30/02; prior State-funded FHIAP parents and childless adults who already have insurance; FHIAP children	Title XIX	Section 1115	0 up to 170% FPL	None	FHIAP	Expansion
14	Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	0% up to 185% FPL	None	FHIAP	Expansion
16	Uninsured targeted low income children ages 0 through 5, and Uninsured targeted low income children ages 6 through 18 These children choose voluntary enrollment in FHIAP	Title XXI	Section 1115 and Title XXI CHIP State Plan	133% up to and including200% FPL 100% up to and including 200% FPL	None	FHIAP	Optional
17	Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	0% up to and including 200% FPL	None	FHIAP	Expansion
18	Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	0% up to and including 200% FPL	None	FHIAP	Expansion
20	Uninsured targeted low income children ages 0 through 18 who choose voluntary enrollment in Healthy Kids ESI	Title XXI	Section 1115 and Title XXI CHIP State Plan	Above 200% up to and including 300% FPL.	None	Healthy Kids ESI child only premium assistance	Optional

g. **FHIAP and Healthy Kids ESI Benefits.** FHIAP and Healthy Kids ESI participants (including children and adults in populations 12, 14, 16, 17, 18 and 20), as described in these STCs, receive the benchmark plan as defined below for FHIAP. The plan is approved at a level actuarially equivalent to mandated Medicaid services.

i. **Changes to the FHIAP and Healthy Kids ESI Benchmark.** Any reduction to the benchmark below the approved level will be submitted to CMS for review and approval as per paragraph 7. Any increase to the benchmark above the approved level will not require approval, but will be subject to the requirements of budget neutrality, as described in these STCs.

ii. **Administration of changes to the FHIAP and Healthy Kids ESI benchmark** are through the Office of Private Health Partnerships (OPHP), which administers FHIAP and Healthy Kids ESI under an interagency agreement with Oregon's Department of Human Services (DHS). OPHP may annually survey Oregon's small group health insurance market to determine the most common benefits and cost-sharing levels, and may adjust the benchmark accordingly. The FHIAP and Healthy Kids ESI benefit benchmark must be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

iii. As directed by HB 2519 (2001 Oregon Laws), the benchmark reflects the benefits commonly offered in Oregon's small group health insurance market.

h. **Benchmark for FHIAP and Healthy Kids ESI.** The benchmark is based on the actuarial value of the member's out-of-pocket expense for the core benefit design (as listed in the benchmark chart.) The values in the chart reflect the actuarial equivalent of mandated Medicaid benefits. Actual benefit designs can vary slightly, but must meet the actuarial equivalency test and have all the required services to be eligible for Federal funding.

FHIAP General Provisions	
Lifetime Maximum	$1,000,000
Pre-existing Condition Waiting Period*	6 Months
Medical Cost Sharing	
Annual Deductible	$750 per individual
Member Coinsurance Level	20 percent
Stop Loss Level	$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	$4,000 per individual

Required Services Prescription Medication Cost Sharing	
Member Coinsurance Level	50 percent
Out-of-pocket Maximum	No out-of-pocket maximum

Other Required Services	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Room	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

* The six month pre-existing condition waiting period is a common feature of individual market plans.

i. **Subsidies**

i. **Premium Assistance levels.** FHIAP and Healthy Kids ESI subsidy levels are based on a family's average monthly gross income and are a percentage of premium cost after any applicable employer contribution

Percentage of FPL	Subsidy Level
Parents and Childless Adults	
0 percent up to 125 percent FPL	95 percent subsidy
125 percent up to 150 percent FPL	90 percent subsidy
150 percent up to 170 percent FPL	70 percent subsidy
170 percent up to and including 200 percent FPL	50 percent subsidy

Children	
0 percent up to and including 200 percent FPL (Medicaid and CHIP Children in populations 12, 14 and 16))	100 percent subsidy
Above 200 percent up to and including 250 percent FPL (populations 20)	Approximately 90 percent subsidy
Above 250 percent up to and including 300 percent FPL (populations 20)	Approximately 80 percent subsidy

j. **Enrollee Contribution Verification.** People enrolled in an employer sponsored insurance plan are reimbursed for the premium withheld from their paychecks (minus the enrollee's share of the premium), provided the enrollee submits verification, at least quarterly, that the premium is being withheld. Copies of paycheck stubs or other employer-generated documentation serve as verification.

k. **Enrollees in the Individual Market**. People in the individual market are billed by FHIAP each month for their portion of the premium. FHIAP combines the member's portion with the subsidy and pays the insurance carrier. Individuals who fail to pay their premium will be disenrolled. Members are billed one month in advance of the date premiums are due to the carrier so that FHIAP can pay carriers in a timely manner. FHIAP does not pay carriers until the member's portion is received. Members are provided a premium grace period of at least 30 days from the billing date. Reminder notices are mailed mid-way through this grace period. Subsidy cancellation notices outlining the program's intent to terminate, are mailed at the end of the grace period. These notices also provide information on the members' right to appeal termination. Individuals are given no less than an additional seven days to remit premium. Terminated individuals are able to re-enroll in the program after being disenrolled for failure to pay premiums. In order to do so, however, they must get back on the FHIAP reservation list. They are placed at the bottom of the list using the request date. If the children of families from zero up to and including 200 percent of the FPL do not pay their premiums, these children can either enroll in Medicaid or CHIP direct coverage or get back on the FHIAP reservation list.

l. **FHIAP and Healthy Kids ESI Contribution Level.** Generally, the employer pays a portion of the premium for FHIAP and Healthy Kids ESI coverage, although there is no State specified minimum employer contribution level.

m. **FHIAP and Healthy Kids ESI Cost Sharing Excluding Premiums.** Cost-sharing requirements or levels for FHIAP and Healthy Kids ESI members are determined by private-sector insurance carriers or employers, not by the Medicaid or CHIP program.

n. **FHIAP Reservation Lists.** The State may employ two reservation lists as a method of continuously adding clients to the FHIAP program (populations 12, 14, 16, 17, and 18). Individuals eligible for Medicaid or CHIP must be provided with the option to enroll in direct coverage at any time while awaiting premium assistance for health insurance provided under an employer-sponsored or an individual market plan.

i. **ESI Premium Assistance reservation list.** A separate list may be employed for individuals interested in obtaining premium assistance for health insurance available through their employers.

ii. **Individual Health Insurance reservation list.** A separate list may be employed for individuals interested in obtaining premium assistance to buy individual health insurance plans when coverage is not available through their employers.

iii. **Outreach to children in families with income from zero through 200 percent of the FPL (Population 14 and 16) currently on the FHIAP Reservation List:** The State will perform targeted outreach to families on the existing reservation list to ensure they are aware that children also have the option to receive direct state plan coverage at any time under Medicaid or CHIP. Families with children will be sent information about direct coverage through Healthy Kids, along with a Healthy Kids application, and a letter encouraging families to apply for immediate coverage rather than wait on FHIAP's reservation list. Families must either complete the application or actively decline direct coverage. All children that choose FHIAP at the point of application and choose to go on the reservation list will also receive information on direct coverage options and be informed that they can move from the FHIAP reservation list or decline CHIP or Medicaid coverage, but still be given the opportunity to choose to move to direct state plan coverage at any time.

iv. **Protections for Children on FHIAP Reservation List:** Families waiting for FHIAP assistance will not lose their place in line or experience any delay as a result of applying for Healthy Kids direct state plan coverage for their children. The State must also inform families that if circumstances change or they change their mind at a later date, they may move their child or children from FHIAP to direct Medicaid or CHIP coverage at any time.

v. **FHIAP Program Openings.** As program openings occur, applications are mailed to families on the FHIAP reservation list(s) on a first come first served basis. Subsidies can be used for ESI or individual health insurance.

vi. **Publication of Reservation List.** The reservation list must be well publicized. It is publicized on the State DHS website and the FHIAP website, and Oregon employers are informed of the reservation list on a regular basis through various state sources (e.g. Employment, Insurance).

vii. **Option for FHIAP Enrollment Cap.** The State may impose an enrollment cap upon the FHIAP program in order to remain under the budget neutrality limit or to address projected budgetary limitations of the FHIAP program.

viii. **Screening for Medicaid and CHIP Eligibility.** All children are screened for Medicaid and CHIP eligibility prior to enrollment in FHIAP. Children will also be screened for Medicaid and CHIP eligibility prior to actual enrollment in FHIAP and enrolled in the appropriate program if the family selects Medicaid or CHIP state plan direct coverage. These families can also receive assistance from choice counselors who can help explain their insurance options.

ix. **Management of FHIAP.** For FHIAP populations 12, 14, 16, 17, and 18 the State may lower the FPL used to determine eligibility; and/or suspend eligibility and/or intake into the program; or discontinue subsidies.

a) No later than 60 days prior to the date of implementation, the State shall submit to CMS its plan for any of these approved actions for review. CMS will complete a review of the plan for implementation, and notify the State of a decision within 60 days of receiving the State's plan.
b) FHIAP will limit the enrollment in the program to a number that can be served within the State and Federal resources allocated to the program, under the constraints of budget neutrality.
c) If sustained enrollment levels would cause FHIAP to exceed its biennial budget, enrollment levels will be allowed to fall either through natural attrition or by one of the caseload control mechanisms outlined above.
d) All children (including Medicaid and CHIP eligible children in demonstration populations 3, 4, 5, 6, 7, 8, and 16,) and certain adults (populations 1, 2, 6, 7 and 8) who would be eligible for OHP Plus benefits always have the option of enrolling in OHP Plus, which includes Medicaid or CHIP state plan direct coverage children, at anytime and the State will keep families informed of this option

x. The FHIAP reservation list does not apply to children applying for Healthy Kids ESI with incomes from zero up to and including 300 percent of the FPL. Children from zero up to and including 200 percent of the FPL will be screened for Medicaid and CHIP enrollment under the Healthy Kids initiative prior to enrolling in Healthy Kids ESI.

o. **Healthy Kids Evaluation.** The Office for Oregon Health Policy and Research will analyze and evaluate the implementation of Healthy Kids, including premium assistance and coverage under the CHIP state plan. The Office will report on the following information using a variety of data sources including a statewide health insurance survey, program administrative data and other quantitative and qualitative data sources. This information will be provided in the State's annual report as specified in STC#28.
   i. Biennial estimates of the number of children who are eligible for but not enrolled in any of the three Healthy Kids options,
   ii. The number of children enrolled in each type (Healthy Kids ESI, and direct state plan coverage options) of program,
   iii. The number of children disenrolled from each type of program, and reasons for disenrollment,
   iv. Enrolment trends (from the inception of Healthy Kids) related to the number of children remaining on the FHIAP reservation list who do not opt for CHIP direct coverage ,
   v. A description of any identified barriers to enrolling or maintaining enrollment of children in any of the program types,
   vi. The quality of care received using nationally accepted HEDIS measures for children,
   vii. Biennial estimates of the number children voluntarily not enrolling in employer-sponsored health coverage who enroll in the program

p. Premium Assistance Evaluation Related to Cost Effectiveness. Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the State's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The State provides limited wrap around services.

i. The State will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:
   a) FHIAP's (Populations 12, 14, 16, 17, and 18) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to
   b) DHS direct coverage (Populations 1 through 11) overall pm/pm costs.

ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in Populations 12, 14, 16, 17, and 18 based on maximum plan out of pocket costs (excluding premium share) to:
   a) Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.[2]

iii. OPHP will monitor program expenditures for HK ESI (Population 20) and compare overall pm/pm subsidized costs to DHS direct coverage (children in populations 3, 4, 5, 6, 7 and 8) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

iv. OPHP will report average aggregate cost sharing for HK ESI plans (Population 20) based on maximum plan out of pocket costs (excluding premium share).

v. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

vi. This information will be provided in the State's annual report as specified in STC#28, as well as progress toward this goal in quarterly reports referenced in Attachment A.

V. DELIVERY SYSTEMS

22. Delivery Systems. The majority of health care services under OHP Plus and OHP Standard are provided through Managed Care Organizations. The MCOs coordinate health care systems, including pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and comprehensive or targeted management of health services. The MCO services take four basic forms under the OHP Medicaid program, which include medical, dental, chemical dependency, and mental health services.

a) **Fully Capitated Health Plan (FCHPs)** - An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient

[2] OHP Plus applies co-pays on an extremely limited basis: none for children, pregnant women, OAA and AB/AD clients with long-term care services, and only limited co-payments for other groups. Thus, they are not likely to provide a fair comparison with FHIAP and ESI cost sharing.

hospitalization. Oregon contracts with FCHPs throughout the State to provide health care services to Oregon Health Plan members.

b) **Physician Care Organization (PCOs) -** An organization contracted to provide physical health services, excluding payment for inpatient hospitalization. The requirements for a PCO include many of the FCHP requirements.

c) **Mental Health Organizations (MHOs) -** An organization contracted to provide outpatient and acute inpatient mental health services. Mental Health services are provided by stand-alone organizations that specialize in such services and are paid on a capitated rate basis. The requirements for an MHO include many of the FCHP requirements.

d) **Dental Care Organizations (DCOs) -** An organization contracted to provide dental services, including preventive care, restoration of fillings, and repair of dentures. Dental services are contracted on a stand-alone basis through a DCO and are paid on a capitated rate basis to provide services to OHP members. The requirements for a DCO include many of the FCHP requirements.

e) **Chemical Dependency Organizations (CDOs) -** An organization contracted to provide outpatient chemical dependency assessment and treatment. Currently, there is one CDO that provides chemical dependency treatment services. Other medical services are either provided through the FCHP or through the State fee-for-service (FFS) delivery system. The requirements for a CDO include many of the FCHP requirements.

f) **Primary Care Manager (PCM) -** A physician or other OHP approved medical provider responsible for providing primary care and maintaining the continuity of care, supervising and coordinating care to patients, initiating referrals to consultants and specialist care. PCMs are not under contract with a managed care organization; they provide health care services through a FFS system, and receive a nominal management fee on a per member per month basis. Compensation to PCMs for direct services is non-risk based and in accordance with the State Plan.

The State shall continue its efforts to increase plan participation in the Oregon Health Plan. In addition, the State shall permit beneficiaries to obtain services outside of the network consistent with treatment of enrollees in plans in rural areas as outlined in 42 CFR Section 438.52 of the Medicaid Managed Care Regulation, Federal Register notice, June 14, 2002, page 41102.

FHIAP members receive health care services through the private insurance market delivery system, according to the contract provisions of the health benefit plan they have selected and enrolled in. FHIAP does not have statutory or regulatory authority to alter any aspects of this delivery system, which is regulated by the Oregon Insurance Division.

VI. GENERAL REPORTING REQUIREMENTS

23. General Financial Requirements. The State shall comply with all general financial requirements under Title XIX and XXI set forth in these STCs.

24. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality. The State shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The State must submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs.

25. **Compliance with Managed Care Reporting Requirements.** The State shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

26. Monthly Calls. CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the State's progress on enrolling individuals into the OHP Standard Demonstration group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

27. **Quarterly Progress Reports.** The State must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. CMS will provide the format for these reports in consultation with the State. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

a. An updated budget neutrality monitoring spreadsheet;
b. An updated CHIP allotment neutrality monitoring spreadsheet;
c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the OHP Demonstration; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the Demonstration; pertinent legislative activities, litigation status and other operational issues;
d. Action plans for addressing any policy, administrative, or budget issues identified;
e. Quarterly enrollment reports required under paragraphs 31 and 34;
f. Evaluation activities and interim findings
g. FHIAP Reporting inclusive of:

i. **Premium Costs (member share and State subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
ii. **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
iii. **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
iv. **Employer Contributions:** By subsidy level, with a weighted overall average.
v. **Overall Premium Cost:** For individual and group, with a weighted overall average.
vi. **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

28. Annual Report. The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration covering Medicaid and CHIP populations. The draft report is also to include, at a minimum, the following

a. **FHIAP activity**: the names of all participating private individual insurance plans and carriers; any changes in participating individual insurance plans and carriers; the number of OHP eligible participants enrolled with each individual insurance plan or carrier; and the amount of premium subsidies paid each individual insurance plan and carrier.

b. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the State's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The State provides limited wrap around services.

i. The State will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:
   a) FHIAP's (Populations 12, 14, 16, 17, and 18) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to
   b) DHS direct coverage (Populations 1 through 11) overall pm/pm costs.

ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in Populations 12, 14, 16, 17, and 18 based on maximum plan out of pocket costs (excluding premium share) to:
   a. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.[3]

iii. OPHP will monitor program expenditures for HK ESI (Population 20) and compare overall pm/pm subsidized costs to DHS direct coverage (children in populations 3, 4, 5, 6, 7 and 8) overall pm/pm costs. Since there is no direct

[3] OHP Plus applies co-pays on an extremely limited basis: none for children, pregnant women, OAA and AB/AD clients with long-term care services, and only limited co-payments for other groups. Thus, they are not likely to provide a fair comparison with FHIAP and ESI cost sharing.

coverage option available to individuals above 200% FPL, however, these results may be distorted.

iv. OPHP will report average aggregate cost sharing for HK ESI plans (Population 20) based on maximum plan out of pocket costs (excluding premium share).

v. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

c. The State shall submit the draft annual report no later than 120 days after the end of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The State shall also submit the title XXI annual State report for its FHIAP children in the Demonstration.

29. Beneficiary Survey. The State shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on MCOs and benefit plans. The State will also monitor and report on disenrollment requests and the reasons for the requests.

30. Final Evaluation Report. The State shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act, and as specified in Section X of these STCs.

31. Enrollment Reporting.

a. Each quarter the State will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the State into the Statistical Enrollment Data System (SEDS) within 30-days after the end of each quarter. The data will be reported for the same groups, categories and in the same manner as the State reports enrollment data for CHIP State Plan population as described in Section 457.740 of the CHIP Final Regulation. SEDS reporting is required for any title XXI-funded population, including populations, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports is required by Eligibility Group (EG) and Type for the title XIX and XXI State Plan and populations.

c. Quarterly Enrollment Reports. Within 60-days of the end of the quarter, the State shall provide CMS with an enrollment report by population showing the end of quarter actual and unduplicated enrollment. The State shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year. The State shall also report the number and percentage of eligibles enrolled in managed care and in FHIAP.

VII. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

32. Title XIX Quarterly Expenditure Reports. The State must provide quarterly expenditure

reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the Demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period and pool payments and certified public expenditures made for the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX of these Terms and Conditions.

33. Reporting Title XIX Demonstration Expenditures. The following describes the reporting of title XIX expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures**. In order to track expenditures under this Demonstration, Oregon must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual.

i. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver.

ii. Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly. To simplify reporting, expenditures from the original Oregon Health Plan Demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan Demonstration.

iii. Up to and including the July-September 2008, QER, Demonstration expenditures are to be reported on Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) in which payments were made for services.

iv. At the end of the Demonstration, expenditures for which payment was made after the last day of the Demonstration, but were for services or coverage provided during the Demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the Demonstration project number assigned by CMS, with a project number extension equal to the DY number of the last year of the Demonstration plus one. For example, if the last year of the Demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

v. All title XIX service expenditures that are not Demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another Demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.

b. **Premium and Cost-Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by Demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.

e. **Use of Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.
   i. "Current": Base 1 EG expenditures;
   ii. "New": Expansion EG expenditures;
   iii. "SSI": Base 2 EG expenditures.

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to (1) all title XIX expenditures with dates of service between November 1, 2002 and the end of the OHP2 Demonstration on behalf of individuals who are enrolled in this Demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan Demonstration that are reported as OHP2

expenditures under (a)(ii) above. However, certain Title XIX expenditures, as identified in paragraph 18 (e)(vi), are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) for which the costs were expended.

h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the later 2-year period, the State must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

i. **Review of Past Expenditure Reporting and Corrective Action.** The State will conduct a review of title XIX expenditures reported on Form CMS-64 during the approval period for the OHP 2 Demonstration to ensure that OHP 2 expenditures subject to the budget neutrality expenditure limit have been reported appropriately, according to the instructions contained in this paragraph. The review will seek to verify that all Demonstration expenditures have been reported on Forms CMS-64.9 Waiver, as required by the STCs, and not on any other CMS-64 form, and that no non-Demonstration expenditures have been reported on Forms CMS-64.9 Waiver for the Demonstration. The review will also ascertain whether Demonstration expenditures have been reported under the correct DY. By the end of the second month following the date of approval of this extension, the State will submit a draft plan to the Project Officer for conducting the review, and for taking action to correct past reporting, subject to CMS approval. All corrective actions must be completed by October 31, 2009. At a minimum, the corrective action must result in the expenditures pertaining to the DY ending September 30, 2003 being identified as DY 01 expenditures, and correspondingly for subsequent DY.

34. Reporting Member Months: The following describes the reporting of member months for OHP 2 Demonstration eligibles from October 1, 2002, forward:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 27 of these STCs, the actual number of eligible member months for all

Medicaid and Demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The State must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the State's knowledge. These member month totals should include only persons for whose expenditures the State is receiving matching funds at the Title XIX FMAP rate. The State must also ensure that member-months reported as FHIAP member-months are also not simultaneously reported as direct coverage member-months. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1, 2,	
PLM Children	3, 4	
Expansion - Parents or Medicaid		
Expansion Parents up to and including 100% FPL	10	
FHIAP (Medicaid)	14	
Base II Direct Coverage		
OAA	7 (aged only), 8 (aged only)	
Blind/Disabled	7 (blind/disabled only), 8 (blind/disabled only)	
Foster Children	5	

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

c. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the eligibility categories described in paragraphs 19(a), 20(a), and 21(b).

35. Standard Medicaid Funding Process. The Standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

36. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section entitled "Monitoring Budget Neutrality For The Demonstration" of these STCS.

a. Administrative costs, including those associated with the administration of the Demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

37. Sources of Non-Federal Share. The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/Local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Should the State exhaust all available Title XXI funding, the State may submit amendments to the CHIP and Medicaid State Plans to create a title XXI funded Medicaid expansion program. This would allow the State the ability to revert to title XIX funds for those populations covered under the Medicaid expansion program. CMS will provide an expedited timeline and complete review of both amendments within 60 days of submittal.

d. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as a Demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to

Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

VIII. GENERAL FINANCIAL REQUIREMENTS FOR TITLE XXI STATE PLAN AND TITLE XXI DEMONSTRATION

Starting November 1, 2007, no expenditures are authorized to be reported on the CMS-21 Waiver and/or 21P Waiver form for title XXI funded populations in this demonstration. The following paragraphs govern reporting of title XXI Demonstration expenditures for the Demonstration approval period ending October 31, 2007, including prior period adjustments.

Title XXI Quarterly Expenditure Reports. The State must report State Plan and Demonstration expenditures using the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outline in section 2115 of the State Medicaid manual. The State shall use Form CMS-21 to report total expenditures for services provided under the approved CHIP plan. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Oregon Demonstration expenditures that do not exceed the State's available title XXI funding.

In order to track expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 Waiver/CMS-21P Waiver reporting process. Title XXI Demonstration expenditures will be reported on separate CMS-21 waiver forms, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made).

a. All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-21 Waiver and/or 21P Waiver.

b. The standard CHIP funding process will be used during the Demonstration. On a separate Form CMS-21B, the State shall provide updated estimates of expenditures for the population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 Waiver and/or 21P Waiver. CMS will reconcile expenditures reported on the Form CMS-21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

38. Oregon will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the waiver period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or Demonstration until the next allotment becomes available.

39. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this Demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

40. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the Demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

41. All Federal rules shall continue to apply during the period of the Demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Population. Before lowering the FPL used to determine eligibility, closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

42. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in paragraph 33.

43. Risk. Oregon shall be at risk for the per capita cost (as determined by the method described below in this Section) for "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and "Expansion - Parents or Medicaid" population (as defined in paragraph 34(a) reporting of Member Months) enrollees under this budget neutrality agreement, but not for the number of such enrollees. By providing FFP for all "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and Expansion - Parents or Medicaid" enrollees, Oregon shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Oregon at risk for the per capita costs for these enrollees, CMS assures that the Federal Demonstration expenditures will reflect Oregon's estimates of savings from managed care, the priority list, and the use of OHP Standard and the FHIAP benefit packages. Oregon will be at full risk for both enrollment and per capita cost for "Expansion – Childless Adults/Other" eligibles (as defined in paragraph 34 (a)).

44. Budget Neutrality Ceiling. The following describes the calculation of the yearly targets mentioned in paragraph 42**.** This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP 2 through the end of the approval period.

a. The Base 1 Subtotal is calculated by multiplying the actual number of member-months for each "Base 1" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.
b. The Expansion Upper Limit is equal to the total number of Base 1 member months times the Oregon Ratio, which is equal to 46.86 percent.
c. Between October 2002, and October 2007, the following rules will govern calculation of the Expansion subtotal.
    i. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is less than the Expansion Upper Limit, then the Expansion Subtotal is calculated by multiplying the actual number of member-months for each Expansion MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.
    ii. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is more than the Expansion Upper Limit, the Expansion MMRG totals are adjusted downward by multiplying them by the ratio calculated by dividing the Expansion Upper Limit by the actual total number of Expansion member-months. The adjusted member-month totals are then used in place of the unadjusted totals to calculate the Expansion Subtotal, following (c) above.

d. Beginning November 2007, and thereafter, the Expansion subtotal will be calculated by multiplying the actual number of member-months for each "Expansion - Parents or Medicaid" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together. The Oregon Ratio calculation will no longer be used after October 31, 2007.

e. The Base 2 Subtotal is calculated by multiplying the actual number of member-months for each Base 2 MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

f. The annual limit is calculated as the sum of the Base 1 Subtotal, Expansion Subtotal, and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the Demonstration.

g. The following table gives the projected PMPM costs for the calculations described above. SFY 2002 Per Capita Costs and the calculated PMPM cost estimates calculated for DY 5 are shown for informational purposes.

(i) Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
AFDC	$420.74	6.2%	$446.83	$474.53	$503.95
PLM-A Pregnant Women	$1,605.08	6.1%	$1,702.99	$1,806.87	$1,917.09
PLM Children	$613.21	6.2%	$651.23	$691.61	$ 734.48

(ii) Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Expansion Parents to 100% FPL	$326.31	6.1%	$346.21	$367.33	$389.74
FHIAP (Medicaid)	$294.48	6.2%	$312.74	$332.13	$352.72

(iii) The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Old Age Assistance	$546.17	5.0%	$573.48	$602.15	$632.26
Blind/Disabled	$1,750.67	5.8%	$1,852.21	$1,959.64	$2,073.30
Foster Children	$735.95	6.2%	$781.58	$830.04	$881.50

45. Future Adjustments to the Budget Neutrality Expenditure Limit.

a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP 2. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. Should the State submit a State Plan Amendment to expand coverage, the State must submit written notification to the Project Officer, including a proposal for how the new or expanded eligibility group will be incorporated into the budget neutrality test for OHP 2.

46. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds shall be returned to CMS.

a. To perform the budget neutrality test, actual cumulative FFP received by the State on OHP 2 Demonstration expenditures are compared to the Federal Share of the cumulative

OHP 2 budget neutrality expenditure limit. The Federal Share of the cumulative budget neutrality expenditure limit is equal to the cumulative budget neutrality expenditure limit calculated above (on a total computable basis) times the Composite Federal Share, which is the ratio calculated by dividing the sum total of FFP received by the State on actual Demonstration expenditures during the approval period, by total computable Demonstration expenditures for the same period. Actual expenditures are those reported on Form CMS-64, as described in paragraph 33 above. The State may include budget neutrality savings from the original Oregon Health Plan Demonstration (11-W-00046/0) in its application of the budget neutrality test for OHP2.

b. Should the Demonstration be terminated prior to the end of the approval period (see paragraphs 9, 11, and 13), the budget neutrality test (including calculation of the Composite Federal Share) will be based on the period in which the Demonstration was active.

c. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

d. Interim Checks/Corrective Action Plan. If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 9	Cumulative budget neutrality cap plus:	0.25 percent
Year 10	Cumulative budget neutrality cap plus:	0.25 percent
Year 11	Cumulative budget neutrality cap plus:	0 percent

X. EVALUATION OF THE DEMONSTRATION

47. Evaluation Design. The State shall consider the Evaluation Guidance in Attachment B and provide the evaluation design based on **i**ts HIFA proposal of May 31, 2002, including:

a. A discussion of the Demonstration hypotheses that will be tested including monitoring and reporting on the progress towards reducing the rate of uninsurance for childless adults and couples;
b. Outcome measures that will be included to evaluate the impact of the Demonstration, including:
    i. What data will be utilized and the baseline value for each measure;
    ii. The methods of data collection; and
    iii. How the effects of the Demonstration will be isolated from those other initiatives occurring in the State; and
c. Any other information pertinent to the State's evaluative or formative research via the Demonstration operations.
d. Progress on identifying a feasible approach for examining the types of coverage being purchased under premium assistance programs and how well it meets enrollees' needs, as well as progress toward exploring options for measuring cost effectiveness outside of whether premium assistance is cost neutral relative to direct state plan coverage options.

The evaluation design must also include the comparative effects of the three health care delivery systems including cost sharing and premiums coupled with the reduced benefit package on selected measures of access to services, quality of care, and communities. The methods and measures to be used will be selected by the State and subject to approval by CMS.

48. Submission of Draft Evaluation Design. The State shall submit to CMS for approval an amended evaluation design for an overall evaluation of the Demonstration no later than 90 days after CMS's approval of the amended Demonstration. At a minimum, the draft design shall include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

49. Interim Evaluation Reports. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

50. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

51. Cooperation with Federal Evaluators. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

Attachment A - Quarterly Report Guidelines

As written within these STCs , the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

I. Introduction

A. Letter from the State Medicaid Director – overview of the report
B. Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)
C. State Contact(s):
    1. Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

II. Title

Title Line One – Oregon Health Plan 2
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 5 (5/01/04 - 4/30/05)
Federal Fiscal Quarter: 4/2004 (7/04 - 9/04)

III. **Events affecting health care delivery during the reporting period, detailing issues and successes -** Identify all significant program developments/issues/problems that have occurred in the current quarter.

A. OHP Demonstration implementation and/or enrollment progress
B. Benefits
C. Grievances and complaints - A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.
    1. Fee-for-service
    2. Managed care
D. Quality of care - Identify any quality assurance/monitoring activity in current quarter.
    1. Fee-for-service
    2. Managed care
E. Access

1. Fee-for-service
2. Managed care

F. Managed care
   1. Approval and contracting with new plans
   2. Any rate certifications
   3. Enrollment and disenrollment
   4. Health plan contract compliance
   5. Financial performance that is relevant to the Demonstration

G. Legislative activities

H. Litigation status

I. Operational issues related to:
   1. OHP Plus
   2. OHP Standard
   3. FHIAP
   4. Future Programs or Insurance products
   5. Identify all significant program developments/issues/problems that have occurred in the current quarter.

IV. **Status of Corrective Action plans –** that address any policy, administrative, or budget issues identified by CMS , the State, or a regulatory entity that impacts the Demonstration. (For example STC 34 (i)).

V. Evaluation activities and interim findings

VI. Appendices

A. Quarterly enrollment reports that at least report:
   1. SEDS reporting
   2. State reported enrollment table

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	
Title XXI funded State Plan	
Title XIX funded Expansion	
Title XXI funded Expansion	
DSH Funded Expansion	
Other Expansion	
Pharmacy Only	
Family Planning Only	
Enrollment Current as of	Mm/dd/yyyy

B. Neutrality reports:
   1. Budget monitoring spreadsheet

2. CHIP allotment neutrality monitoring spreadsheet
3. Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

VII. Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

The State may also add additional program headings as applicable.

Attachment B – Evaluation Guidelines

Section 1115 Demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS requires States with Demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their Demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to Demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the Demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or Demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the Demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality Demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and
    - Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
    - Hypothesis or research questions to be investigated;
    - Goals, such as:
        - Increase Access
        - Impact of title XXI cost sharing waiver for children in premium assistance
        - Cost Effectiveness
        - Improve Care Coordination
        - Increase Family Satisfaction and Stability
    - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
    - The type of research design(s) to be included -
        - Pre/Post Methodology
        - Quasi-Experimental
        - Experimental
    - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
    - Enrollment and outreach records;
    - Medicaid claims data;
    - Vital statistics data;
    - Provide record reviews;
    - School record reviews; and
    - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
    - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
    - How findings will be incorporated into outreach, enrollment and education activities;
    - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
    - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the Demonstration intervention.

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ATTACHMENT C

Exhibit 1: Glossary of Terms Related to title XIX and XXI funded Children

- **Healthy Kids*:*** Created by House Bill 2116 during Oregon's 2009 Legislative Session, *Healthy Kids* provides coverage for all uninsured children up to age 19 in the State. The plan offers comprehensive health care coverage that includes dental, vision, mental health and physical health care. The objective of *Healthy Kids* is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. *Healthy Kids* includes three different program components:

    - 1) Existing CHIP and Medicaid direct coverage (OHP Plus),
    - 2) Premium assistance administered by the Office of Private Health Partnerships (family coverage under FHIAP for children through 200 percent of FPL and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL, and
    - 3) A new private insurance component, Healthy KidsConnect, which will be provided under the CHIP state plan.

    The Federal government will provide match for children up to and including 300 percent of the FPL. The State will also permit uninsured children above 300 percent of the FPL to purchase the new plan under Healthy KidsConnect without State or Federal match.

- **Family Health Insurance Assistance Program (FHIAP) for Families Enrolled in ESI or Individual Market:** The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.

    - **FHIAP Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL:** Subsidies are available to children in this income category through Healthy Kids ESI. Children determined eligible by DHS are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP pays premium subsidies range from 50 to 95 percent for adults and 100 percent of the premium for children in this income group. Individuals (adults and children) who enroll in this program are subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP or CHIP direct coverage (OHP Plus) and children who choose FHIAP can move back to State plan direct coverage at any time.

    - **Healthy Kids ESI/Child Only Premium Assistance for children in families with incomes above 200 up to and including 300 percent of FPL who have access to ESI:** Subsidies are available to children in this income category through ESI or the

State's private insurance option, Healthy KidsConnect. Children in families with incomes above 200 percent FPL are not eligible for CHIP direct coverage (OHP Plus). Sliding scale subsidies are available for children who are able to enroll in the family's ESI.

- Families with incomes above 200 through 250 percent of FPL will receive State subsidies equaling about 90 percent of the child's monthly premium.
- Families with incomes above 250 through 300 percent of the FPL will receive State subsidies equaling about 80 percent of the child's monthly premium.
- All other cost-sharing is subject to the cost of the employer plan.

- **Healthy KidsConnect:** This is a CHIP state plan direct coverage option provided under the State's separate child health program. Sliding scale subsidies are available to children who enroll in State-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package.
  - Families with incomes above 200 percent up to and including 250 percent of FPL will receive State subsidies equaling about 90 percent of the child's monthly premium; and
  - Families with incomes above 250 percent up to and including 300 percent of the FPL will receive State subsidies equaling about 80 percent of the child's monthly premium.
  - Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.

- **Oregon Health Plan (OHP) Plus:** OHP Plus is a CHIP state plan direct coverage option provided under the State's separate child health program. The State provides Secretary-approved coverage that is the same as coverage offered under the State's Medicaid program. The State's benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration for its entire Medicaid population. Medically necessary services are defined in the Prioritized List. The benefit package includes mandatory services for children, including well-baby and well-child visits, immunizations and dental services. There are no premiums, co-payments, or deductibles for children in direct coverage.

- **FHIAP Reservation List:** Oregon uses reservation lists to manage enrollment in the premium assistance program. Only families with incomes through 200 percent of the FPL are eligible for FHIAP and subject to the reservation list.

  - **The individual reservation list** is for applicants who do not have access to ESI.
    - Once approved, individuals may select an individual health plan from a list of approved FHIAP insurers.
    - Only plans that meet FHIAP's benchmark are offered to individual members.

  - **The group reservation list** is for applicants who have access to ESI.
    - ESI plans must meet FHIAP's benchmark.