

**OREGON DEMONSTRATION
FACTSHEET**

March 30, 2009

Name of Section Demonstration/Waiver: Oregon Health Plan 2
Date Proposal Submitted: June 6, 2002
Date Proposal Approved: October 15, 2002
Date Implemented: November 1, 2002
Date Expires: October 31, 2007

Date Renewal Submitted: October 16, 2006
Date Extension Approved: November 1, 2007
Extension Expiration: October 31, 2010

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) approved section 1115 waiver for the OHP Demonstration for a 5-year period, beginning on February 1, 1994. The Oregon Health Services Commission, with CMS, approved and developed the Prioritized List of Health Services (PL) which stipulates covered services under OHP. This list is updated every 2 years (biennial review), whereby services are added, deleted, or moved to a different ranking within the list. The driving forces behind the OHP demonstration program were on the basis of several guiding principles; Expand Eligibility, Prioritized the list of health services, and Managed Care.

In October 2002, OHP was reauthorized for 5 years as a combined demonstration which incorporated new HIFA authorities into the existing plan, giving the state a two-tiered health benefit plan for certain eligibility groups, and the Family Health Insurance Assistance Program (FHIAP), a health insurance subsidy program for certain eligibility groups that choose to purchase private health insurance (both individual and employer-sponsored group insurance). Combining the three programs into one allowed Oregon to provide coverage to populations not previously covered under OHP.

On October 16, 2006, the State of Oregon requested a 3 year extension of its Medicaid and CHIP section 1115(a) demonstration, known as the Oregon Health Plan 2 (OHP 2). With this extension's approval, CMS directed the State to move uninsured adults not eligible for Medicaid or CHIP from its Title XXI expansion populations into Title XIX expansion populations. The Special Terms and Conditions were amended to incorporate the use of a "Reservation List," to enable the State to manage the application and enrollment process of the expansion eligibility groups and CMS approved the 2007-2009 Prioritized List of Health Care Services.

AMENDMENTS – N/A

ELIGIBILITY

Within OHP, the State provides health care to Oregonians who have applied and been determined eligible with incomes up to 185 percent FPL. This includes specified Medicaid mandatory and optional groups under the Oregon State plans, as well as specified expansion groups included under this demonstration. Medicaid State plan and optional groups are served in the component known as OHP Plus, or FHIAP if it is available and the CHIP optional group are served in FHIAP. Expansion adult populations are provided with OHP standard benefits, or FHIAP if available. The mandatory and optional Medicaid State plan populations 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 by the demonstration. Medicaid mandatory and optional state plan groups 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 expressly waived by the demonstration.

The CHIP program in Oregon is a separate program from Medicaid, and is governed by an CHIP State plan. CHIP eligible children with access to employer sponsored insurance, including optional groups under the State plan, are incorporated into OHP and provided benefits through FHIAP, in a similar fashion to the Medicaid populations. This group is subject to all applicable CHIP laws and regulations in accordance with the State plan, except as expressly waived.

DELIVERY SYSTEM

Prepaid health plans.

BENEFITS

Medicaid in Oregon provides preventive care, primary care, acute care, long-term care, and prescription drugs. Through its “Early and Periodic Screening and Diagnostic and Treatment” program (EPSDT), Medicaid provides children with the preventive care and treatment they need to reach their optimal health and development. Additionally within the State, benefits are based on the use of a “prioritized list” of health services. The list was developed by the Oregon Health Services Commission, a governor-appointed group of physicians and consumers.

What is covered on the Prioritized List

The following services are examples of what may be covered by your benefit package:

- Diagnosis (services to find out what is wrong)
- Physician services
- Check-ups (medical and dental)
- Family planning services
- Maternity, prenatal, and newborn care
- Prescription services
- Hospital services
- Comfort care and hospice
- Dental services
- Alcohol/drug treatment
- Mental health services

What is not covered on the Prioritized List

- Treatment for conditions that get better on their own, like colds
- Conditions that have no useful treatment
- Treatments that are not generally effective
- Cosmetic surgeries
- Gender changes
- Services to help women get pregnant
- Weight loss programs

COST SHARING

Premiums

Premiums range from \$9 to \$20 per person per month. The amount is based on your income and the size of your family

Co-payments

- Children under age 19 do not have co-payments.
- The OHP Standard benefit package does not have co-payments.
- The OHP Plus and OHP with Limited Drug benefit packages do have co-payments for specific outpatient services and prescription drugs for some adults. Each provider will know if a co-payment is required and how much to charge. (The OMAP Medical Care Identification shows the benefit package and the co-payment information for each member of the household.) Some adults are exempt from co-payments. Co-payments are not charged to adults who are:
 1. Pregnant
 2. Getting services under the Home and Community-Based Waiver
 3. Getting services under the Developmental Disability Waiver
 4. Inpatients of a hospital or nursing facility
 5. American Indians or Alaska Natives who are members of federally recognized Indian tribes
 6. Eligible for benefits through Indian Health Services

Services are exempt from co-payments

For the OHP Plus and OHP with Limited Drug benefit packages, co-payments are not charged for the following:

- Emergency services
- X-ray and lab services
- Durable medical equipment and supplies
- Routine immunizations
- Drugs ordered through the State's home-delivery pharmacy program
- Family planning services and supplies
- If you are enrolled in a managed care plan, the services and drugs covered by that plan

Services subject to co-payments

For the OHP Plus or OHP with Limited Drug benefit packages, co-payments are charged for certain types of outpatient services. There are exceptions, as noted in other answers. Your provider will know which services are subject to a co-payment and how much to charge. Your provider may charge \$3 per visit per day. You may be charged a co-payment when you get the following services:

- Office visits
- Home visits
- Hospital emergency room services when there is not an emergency
- Outpatient hospital services
- Outpatient surgery
- Outpatient treatment for chemical dependency
- Outpatient treatment for mental health
- Occupational therapy
- Physical therapy
- Speech therapy
- Restorative dental work
- Vision exams

Prescriptions

Co-payment, of \$2 for generic drugs and \$3 for brand-name drugs

The OHP Standard benefit package does not have co-payments.

Dental

The OHP Plus and OHP with Limited Drug benefit packages have a \$3 co-payment for restorative dental services. Diagnostic dental services do not have a co-payment. Diagnostic services include oral examinations to identify changes in your health or dental status. They also include routine cleanings, x-rays, lab work and tests needed to make a diagnosis or treatment decision.

The OHP Standard benefit package does not have co-payments.

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