

**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 Health Authority

All requirements expressed in Medicaid and CHIP laws, regulations and policies apply to this Demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Such deviations from Medicaid requirements are limited in scope to expenditures related to the following populations affected by the Demonstration:

Populations Affected by OHP

The following title XIX and title XXI State plan populations, and Demonstration-only Expansion Populations are affected by this Demonstration and are listed for purposes of references in the waiver list and expenditure authorities.

Title XIX State Plan Populations

Population 1: Medicaid mandatory pregnant women included in the State plan with income from 0 up to 133 percent of the Federal poverty level (FPL).

Population 2: Medicaid optional pregnant women included in the State plan with income from 133 up to 185 percent of the FPL.

Population 3: Medicaid children 0 through 5 included in the State plan with income from 0 up to 133 percent of the FPL and infants (age 0 to 1) born to women receiving Medicaid benefits at the time of birth with incomes up to 185 percent of the FPL.

Population 4: Medicaid children ages 6 through 18 included in the State plan with income from 0 up to 100 percent of the FPL, and beginning January 1, 2014, Medicaid children with income from 100 up to 133 percent of the FPL.

Population 5: Medicaid mandatory foster care and substitute care children (as defined in the STCs).

Population 6: Medicaid mandatory AFDC section 1931 low-income families (as defined in the STCs).

Population 7: Medicaid mandatory elderly, blind, and disabled individuals with incomes at the SSI level of the FPL (as defined in the STCs).

Population 8: Medicaid optional elderly, blind and disabled individuals with incomes above the Supplemental Security Income (SSI) level of the FPL (as defined in the STCs).

Population 21: Women under the age of 65 who have been screened and diagnosed through the State's National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and cervical cancer, and are not otherwise covered under creditable coverage with respect to the needed treatment for breast and cervical cancer.

Demonstration Expansion Populations

On January 1, 2014 expenditure authority for many Demonstration Expansion populations will end. When the State amends its Medicaid or CHIP State plan to include some or all of these populations after that date, the State will submit an amendment to the Demonstration updating the populations that will be affected by the Demonstration.

Population 9: Until January 1, 2014, general assistance expansion individuals with income from 0 up to and including 43 percent of the FPL (as defined in the STCs).

Population 10: Until January 1, 2014, expansion parents ages 19 and older with income from 0 up to 100 percent of the FPL (as defined in the STCs).

Population 11: Until January 1, 2014, expansion childless adults age 19 and older with income from 0 up to 100 percent of the FPL (as defined in the STCs).

Population 14: Until January 1, 2014, participants who would have been eligible for Medicaid but choose FHIAP instead.

Population 16: Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with income 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 premium assistance under FHIAP.

Population 17: Until January 1, 2014, uninsured parents of children who are eligible for Medicaid or CHIP, who are themselves ineligible for Medicaid/Medicare with income from 0 up to and including 200 percent of the FPL enrolled in FHIAP (as defined in the STCs).

Population 18: Until January 1, 2014, uninsured childless adults who are not eligible for Medicaid/Medicare with income from 0 up to and including 200 percent of the FPL enrolled in FHIAP (as defined in the STCs).

Population 20: Uninsured children ages 0 through 18 with income from above 200 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 premium assistance under Healthy Kids ESI.

Population 22: Children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL and uninsured children from ages 6 through 18 with income from 100 up to and including 200 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP State plan; title XXI children ages 0 through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP State plan (under Healthy KidsConnect); and targeted low-income children from conception to birth with income from 0 up to 185 percent of the FPL under the CHIP State Plan.

Population 12 is no longer applicable (in prior demonstration periods, this population included individuals with incomes from 0 up to 170 percent of the FPL who were enrolled in FHIAP as of September 30, 2002), but all such individuals would be otherwise covered in other populations in the current demonstration.

Population 13: is no longer applicable (in prior demonstration periods, this population included, pregnant women with incomes from 170 up to and including 185 percent of the FPL, but has been combined with Population 2, which now covers all pregnant women with incomes from 133 up to and including 185 percent of the FPL, under the title XIX State plan.)

Populations 15 and 19 are no longer applicable (under prior Demonstration periods, these were for individuals covered under the title XXI State plan as of November 1, 2007), and are no longer subject to this Demonstration.

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this Demonstration renewal and amendment from through June 30, 2017. As specified below, on January 1, 2014 certain waiver authorities will end. When the State amends its Medicaid or CHIP State plan to include some or all of these populations after that date, the State will submit an amendment to the Demonstration updating the populations that will be affected by the Demonstration.

1. Statewideness/Uniformity

**Section 1902(a)(1)
42 CFR 431.50**

To enable the State to provide benefits through contracts with managed care entities that operate only in certain geographical areas of the State. (Applies to all populations listed above except 14,16, 17, 18, 20 and the portion of population 22 with income from above 200 up to and including 300 percent of the FPL .)

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 populations, and to enable the State to limit the scope of services for optional and expansion populations. (Applies to populations 1 -11, 21 and the direct coverage portion of population 22, with the exception of 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**

Until January 1, 2014, 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, 14, 17, 18 and 22).

4. Eligibility Procedures

**Section 1902(a)(10)(A) and
1902(a)(34)
42 CFR 435.401 and
435.914**

Until January 1, 2014, 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, 14, 17, 18 and 22.)

5. Freedom of Choice

**Section 1902(a)(23)(A)
42 CFR 431.51**

To enable the State to restrict freedom-of-choice of provider by offering benefits only through managed care entities (and other insurers) in a manner not authorized by section 1932 because beneficiaries may not have a choice of managed care entities. This does not authorize restricting freedom of choice of family planning providers. (Applies to all populations listed above.)

6. 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 all Populations above.)

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

To the extent necessary to allow the State to not pay DSH payments when hospital services are furnished to managed care enrollees. (Applies to populations 1-11, 13, 21 and for population 22, applies only to those in OHP direct services)

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

To enable managed care entities to permit enrollees a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all populations 1-11, 21 and the direct service population of 22.)

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

Until January 1, 2014, 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, 14, 17, and 18.)

10. Premiums Section 1902(a)(14) insofar as it incorporates 1916 and 1916(A)

To enable Oregon to impose premiums and cost sharing in excess of statutory limits on demonstration eligible individuals enrolled in the FHIAP and Healthy Kids ESI programs through December 31, 2013.

Title XXI Waiver Authority

All requirements of the CHIP expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the CHIP State plan requirements contained in title XXI of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this Demonstration renewal and amendment from through June 30, 2017. The following waivers apply to title XXI Demonstration Populations 16, 20 and 22.

1. Benefit Package Requirements

Section 2103

To permit the State to offer a benefit package for Demonstration Populations 16, 20 and 22 that does not meet the requirements of section 2103 of the Act, as defined in Federal regulations at 42 CFR 457.410(b), but instead equals the private or ESI plan coverage that the beneficiary has elected.

Title XXI - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, State expenditures for the provision and administration of child health assistance to the demonstration populations described below (which would not otherwise be included as matchable expenditures under title XXI), shall for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of the title XXI statute will be applicable to such expenditures, except as specified below as not applicable to these expenditure authorities.

- a. Population 16:** Until January 1, 2014, 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 premium assistance under FHIAP.
- b. Population 20:** Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL; and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI.

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities:

1. 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 subject beneficiaries to the cost sharing required under the private or ESI plan coverage that the individual has elected.

Title XIX - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this Demonstration, be regarded as expenditures under the State's Medicaid title XIX State plan.

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.
2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.
3. Expenditures for costs of chemical dependency treatment services for eligible individuals 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.
4. 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.)
5. Until January 1, 2014, Expenditures for health care-related costs for Demonstration Populations 9, 10, 11, 14, 17, and 18.
6. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 54 and as described in Section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues

from tuition or high risk pool health care premiums. This expenditure authority will not be renewed or extended after June 30, 2017.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

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

TITLE: Oregon Health Plan

AWARDEE: Oregon Health Authority

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 these STCs are the Oregon Health Authority (formerly 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 amended STCs are effective July 1, 2012, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. The amended STCs are effective July 1, 2012, through June 30, 2017, unless otherwise specified.

The STCs have been arranged into the following areas:

- I. Preface
- II. Program Description, Objectives, Historical Context;
- III. General Program Requirements;
- IV. The Oregon Health Plan;
- V. Delivery System Transformation;
- VI. Capitation Rates and Performance Measures;
- VII. Measurement of Quality of Care and Access to Care;
- VIII. Calculating the Impact of Health Systems Transformation and Reductions in Designated State Health Program Funding;
- IX. Designated State Health Programs;
- X. General Reporting Requirements;
- XI. General Financial Requirements for Title XIX;
- XII. General Financial Requirements for Title XXI;
- XIII. Monitoring Budget Neutrality for the Demonstration;
- XIV. Evaluation of the Demonstration; and
- XV. Additional attachments have been included to provide supplementary information and guidance for specific STCs.
 1. Attachment A: Quarterly Report Guidelines

2. Attachment B: Evaluation Guidelines
3. Attachment C: Glossary of Terms
4. Attachment D: Summary Chart of Demonstration Populations
5. Attachment E: Menu Set of Quality Improvement in Focus Areas
6. Attachment F: CCO Services Inventory
7. Attachment G: DSHP Claiming and Documentation Protocols
8. Attachment H: Calculating the Impact of Health Systems Transformation

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases on February 1994. Phase I of the Medicaid Demonstration Project started on February 1, 1994. Originally, the Demonstration affected 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 added the aged, blind, disabled, and children in State custody/foster-care. Following the creation of title XXI of the Act by Congress in 1997, Oregon's Children's Health Insurance Program (CHIP) was incorporated into the OHP. From its inception, Oregon's CHIP provided eligibles with the same benefit package available to all OHP-Medicaid clients.

Objectives

Under the Demonstration, Oregon strives to promote the objectives of title XIX and title XXI by:

- Providing health care coverage for uninsured Oregonians;
- Providing a basic benefit package of effective services;
- Insuring broad participation by health care providers;
- Decreasing cost-shifting and charity care;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Making Medicaid available to people living in poverty regardless of age, disability or family status;
- Structuring benefits (what is covered), using a prioritized list of health care conditions and treatments.
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
 - Improving the individual experience of care;
 - Improving the health of populations; and
 - Reducing the per capita costs of care for populations through such improvements.

Historical Context: Demonstration Extensions and Amendments

1994 Initial Demonstration Approval

CMS initially approved the Oregon Health Plan (OHP) section 1115 Demonstration for a 5-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs by using managed care and a Prioritized List of Health Services. This list is updated every 2 (two) years, whereby services are added, deleted, or moved to a different ranking within the list.

1998 Demonstration Extension

The OHP was extended by CMS for a 3 (three) year period through 2001.

2002 Demonstration Extension and Amendment

CMS approved Oregon's application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) Demonstration for 5 (five) years through 2007. 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.

2005 Demonstration Amendment

CMS approved a Demonstration amendment that changed coverage under the Demonstration which placed 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.

2007 Demonstration Extension

CMS revised the structure of the populations within the Demonstrations to reflect updated law and CMS policy. Uninsured adults not eligible for Medicaid or CHIP were removed from the title XXI expansion populations and 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, were made eligible 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). In addition, it was clarified that mandatory pregnant women and children 0 to 1 year of age receive full Medicaid State Plan benefits, subject to necessary pre-authorizations.

2009 Demonstration Extension and Amendment

CMS approved an amendment to the Demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children through age 18 in the State with family incomes from 0 up to and including 300 percent of FPL. The State also provides access to coverage for children above 300 percent of FPL, but does not receive FFP for this population. Healthy Kids includes four different program components: 1) Existing CHIP direct coverage (OHP Plus), 2) premium assistance through FHIAP, 3) Child-only premium assistance administered by the Office of Private Health Partnerships (Healthy Kids ESI), and 4) A private

insurance component (Healthy KidsConnect). Through Healthy Kids, children from 0 up to and including 200 percent of the FPL have the choice between title XXI CHIP direct coverage, premium assistance through FHIAP, or Healthy Kids ESI. Children from above 200 up to and including 300 percent of the FPL have the choice between Healthy Kids ESI or coverage under Healthy KidsConnect.

In addition, the last CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed 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; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

2012 Demonstration Amendment

As reflected in these STCs, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and a reduction of other benefits (reflected in 13 lines of the Prioritized List of Health Services for FFY12-13). This amendment is effective January 1, 2012.

2012 Demonstration Extension and Amendment

In July 2012, CMS approved an amendment and extension related to Oregon’s Health System Transformation

The amendment and extension of OHP seeks to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The design and implementation of the Oregon demonstration will be driven locally; overall, the amended 1115 demonstration seeks to achieve two equally important and inter-related goals:

- **Goal 1: Medicaid Statewide Spending Growth Reduction.** The demonstration will bend the Medicaid cost curve to achieve a 2 percentage point reduction in Medicaid per capita trend by year 13 of the demonstration. Progress toward and ultimate achievement of this goal will be measured by reviewing the State and Federal cost of purchasing care for individuals enrolled in Coordinated Care Organizations (CCOs).

- **Goal 2: Improving Statewide Care Quality and Access.** Oregon Medicaid beneficiaries will experience improved access to care and quality of care over the five-year program period of July 2012 – June 2017, compared to a baseline level of performance.

The Demonstration authorizes expenditures on certain Designated State Health Programs (DSHP), and in order to align incentives and support progress, if Demonstration goals are not realized after interventions have been pursued to reorient progress, CMS will reduce DSHP funding as described in Section VIII.

Oregon seeks to achieve these goals without any diminution of eligibility or benefits. Instead, the State will pursue several different approaches, or “levers” to drive savings and quality improvement:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs
- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient-centered primary care homes (PCPCH)
- Lever 5: Use of flexible services

Oregon plans to realize these goals through better care management, increased provider and community accountability, payment reform, administrative efficiencies, use of flexible services, promoting the provision of services by nontraditional health workers, and expanding access through improvements to the State’s health care workforce.

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 Federal law, regulation, or policy, 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 earlier of the date such State legislation becomes effective, or the date such legislation was required to be in effect under Federal 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. Consistent with Oregon's community-focused health systems transformation approach, the State shall undertake a robust public process to ensure community engagement in the development and submission of amendments to the Demonstration. 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, prior to submission of the requested amendment;
- b. A data analysis which identifies the specific 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.

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request 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.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the Demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:

- i. **Historical Narrative Summary of the Demonstration Project:** 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.

- ii. 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.
- iii. 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.
- iv. Quality: The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the Demonstration.
- v. Financial Data: 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.
- vi. Evaluation Report: 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.
- vii. Documentation of Public Notice 42 CFR section 431.408: The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public

during the comment period and how the State considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination:** The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b. **Phase-out Plan Requirements:** The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c. **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- d. **Federal Financial Participation (FFP):** 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.
- e. **Post Award Forum:** Within six months of the Demonstration's implementation, and

annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the Demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the Demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraphs 63 and 64 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 65.

10. **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.

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

12. **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.

13. **Submission of State plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA)**
Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many Demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the Demonstration to the extent that such populations will be subject to the Demonstration. In addition, the State will submit by April 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan

will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

- a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
 - i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.
 - iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.
 - v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.
- b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements,
- c. Transition Plan Implementation:
 - i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
 - ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the

enrollees.

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, Tribal Consultation, and Consultation with Interested Parties.**

The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State.

In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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. **Overview of 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). Four separate benefit packages are offered by OHP: OHP Standard benefits, OHP Plus benefits, FHIAP premium assistance, and HealthyKids ESI premium assistance. Beneficiaries enrolled in OHP also may receive services identified in subparagraph (e.viii) below, which are not included in the OHP or affected by this

Demonstration. During the demonstration period, the State may not reduce eligibility or covered benefits.

- a. **ACA Implementation.** As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII); benefits; and cost sharing will revert to the Medicaid State plan and comply with Medicaid regulatory and subregulatory guidance. Benefits under the Oregon Health Plan Demonstration will include the provision of Essential Health Benefits identified in the Medicaid/CHIP State plan.
- b. **Eligible Populations.** Within OHP, the State will provide health care 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 Medicaid mandatory and optional groups under the Oregon State plans, as well as Demonstration expansion groups as defined in the **–Summary Chart of Demonstration Populations”** (Attachment D). Over the course of this demonstration, the State will not make substantive or administrative changes to the Demonstration that would result in a reduction in Demonstration eligibility for any of the Medicaid or CHIP state plan populations or expansion populations. CMS will provide guidance to the State regarding permissible changes to implement the Affordable Care Act Medicaid coverage expansion in 2014.
- c. **Applicability of Medicaid and CHIP Laws and Regulations.** All requirements expressed in Medicaid and CHIP laws, regulations and policies apply to all the populations affected by this Demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are 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 in Attachment D) seeking or obtaining coverage through OHP will be screened for Medicaid and CHIP eligibility at initial application at least every 12 months, and prior to enrollment in FHIAP or Healthy Kids ESI . Applicants will be offered an informed choice of voluntary enrollment in direct coverage under the Medicaid or CHIP HealthyKids 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.
- e. **Summary of OHP Benefit Structure.** 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, or Healthy Kids ESI, both of which will be ending on December 31, 2013). Most beneficiaries under the public sector programs receive services through managed/coordinated care delivery systems.

- i. Mandatory Medicaid State Plan eligibles receive the OHP Plus benefit (populations 1, 3, 4, 5, 6, 7 and 21 in Attachment D) unless they are children who have elected direct Medicaid coverage outside of OHP, administered by Oregon Health Authority (OHA) (formerly 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 in Attachment D).
- ii. Adults who are not eligible under the State plan are enrolled in OHP Standard (populations 10 and 11 in Attachment D) except if the condition in iii is met.
- iii. Until December 31, 2013, enrollment in FHIAP is required for adults eligible for OHP Standard (populations 10 and 11 in Attachment D) if ESI is available.
- iv. All mandatory and optional Medicaid State Plan eligible children younger than 21 years old are entitled to elect to receive direct Medicaid coverage outside of OHP including all State Plan and EPSDT covered services (populations 3, 4, 5, 6, 7, and 8 in Attachment D).
- v. Through December 31, 2013, FHIAP is Oregon's primary premium assistance program. Through FHIAP, eligible uninsured Oregonians (adults and children in populations 12, 14, 16, 17 and 18, as set forth in Attachment D) can elect to receive premium subsidies for the purchase of private health insurance instead of direct coverage. This option applies to enrollment in both individual and employer-sponsored insurance. Both adults and children applying for FHIAP benefits are subject to the FHIAP reservation list.
- vi. Children enrolled in CHIP in families with income from zero up to and including 200 percent of the FPL (Population 16 in Attachment D) can instead receive premium assistance through Healthy Kids ESI if employer-sponsored insurance is available and voluntarily chosen by the family. These children apply for coverage through OHA and are not subject to the FHIAP reservation list.
- vii. Children in families with income above 200 up to and including 300 percent of the FPL can receive premium assistance through Healthy Kids ESI if employer-sponsored insurance is available and chosen by the family (population 20 in Attachment D) and coverage under Healthy KidsConnect.

- viii. The following Medicaid services and expenditures are not affected by the OHP Demonstration, and are available as otherwise provided under the State plan:
1. Mental Health Facility – DSH Adjustment Payments;
 2. Long Term Care Services;
 - a. Nursing Facility Services
 - b. Home- and Community-Based Services
 - c. Community Supported Living Services
 - d. Programs of All-Inclusive Care Elderly
 3. ICF/MR Services;
 4. Medicare Premium Payments;
- f. **Prioritized List of Health Services.** One of the distinguishing features of the OHP Demonstration is that OHP benefits are 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.
- i. **Oversight**
 1. **The Health Evidence Review Commission (HERC)** - The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Office for Oregon Health Policy and Research. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review 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 in order to ensure the Prioritized 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 following website:
<http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml>.
During the demonstration period and as specified below the State will not reduce benefits.

- iii. **Ordering of the Prioritized List.** The Prioritized 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).
- iv. **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.
- v. **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 coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the prioritized list of health services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, 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 for the “2012-2013” Prioritized List of Health Services.

- i. Beginning January 1, 2012, the 2012-2013 Prioritized List of Health Services contains 692 lines. Lines 1-498 are funded to provide the OHP Plus and Standard benefit packages.

- ii. The 2012-2013 Prioritized List will stay in effect until September 30, 2014 to allow time for a transition from the ICD-9 code system to the new, more extensive ICD-10 codes, which is currently underway.
 - iii. Beginning October 1, 2014, the 2014-2015 Prioritized List of Health Services will go into effect and will change the line number, structure and composition as a result of the biennial review and the conversion to ICD-10-CM. The State will maintain the funding line at the same position relative to the 2012-2013 List (currently between Chronic Sinusitis and Keratoconjunctivitis and Corneal Neovascularization) on the 2014-2015 List and for the remainder of the Demonstration.
- h. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:
- i. The state will maintain the cutoff point for coverage at the same position on the List relative to the 2012-2013 List for the remainder of the Demonstration as noted above in subparagraph (g). For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request (in compliance with paragraph 7) will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the 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 XIII.
 - ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.
 - iii. For a change to the list not defined above that meets the terms of paragraph 6, an amendment request.
- i. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The EPSDT benefit under OHP Standard and OHP Plus is limited by the coverage under the applicable benefit package, but all other requirements of EPSDT, including the provision or arrangement of all covered services to treat a condition identified during an EPSDT screening that is within the scope of the benefit package available to the individual.
 - j. **Non Traditional Health Workers (NTHW).** NTHWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and

doulas. NTHWs may serve individuals currently enrolled in Managed Care Entities (MCEs), and/or through the State's FFS delivery system.

- k. **Patient Centered Primary Care Homes (PCPCH):** The State includes PCPCH services in the OHP Standard and Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement and obtaining agreement to participate. The State will work with CCOs to provide the enrollee with notice that s/he has been enrolled in a PCPCH. In addition this notice will provide the participant with information informing them of their right to opt out.

19. Oregon Health Plan Standard (OHP Standard)

- a. **Eligibility and Enrollment.** Until January 1, 2014, the OHP Standard benefit package is provided to uninsured parents and childless adults ages 19 and older (Populations 10 and 11, in Attachment D 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.
 - 1. 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, in Attachment D respectively.)
 - 2. If a parent or childless adult is found ineligible for FHIAP, the uninsured parent or childless adult will be enrolled in OHP-Standard as long as enrollment slots are available.
 - ii. **Reservation List.** Until January 1, 2014, the State may employ a reservation list as a method of adding clients to the OHP Standard program. (Applies to populations 10 and 11 in Attachment D)
 - 1. Applications for OHP Standard will be provided to potential clients based on the projected budget limitations of the OHP Standard program.

2. 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.
3. 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.**

1. For the OHP Standard 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.
2. Beginning with the December 1, 2009 approval of this amendment to the Demonstration, the State will begin to use a new reservation list.
3. 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.
4. 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, OHA will periodically select individuals from the reservation list, using a randomized sampling methodology. The State will:
 - i. Send applications to selected individuals.

- ii. Determine eligibility for the selected individuals who submit applications.
 - iv. **Eligibility Redeterminations.** Parents and childless adults ages 19 and older (Populations 10 and 11, in Attachment D 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. Become eligible for Medicare; 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. 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 full inpatient hospital benefit and a hospice benefit as add-on services. This benefit package will be offered through December 31, 2013.
- d. **Changes to the OHP Benefit Package.** 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 XIII. Any increases to the approved OHP Standard core set of services shall not include abortion or Death with Dignity services.

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	✓
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 through December 31, 2013:

- 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 12-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) through December 31, 2013

- a. **Eligibility** - Through December 31, 2013, the Medicaid State plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, 9 and 21 in Attachment D) who have not elected benefits through FHIAP are served in the component known as OHP Plus.
- b. **Eligibility Redeterminations.** Medicaid State plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, 9 and 21 in Attachment D) 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.
- c. **Benefits.** The OHP Plus benefit package is the Prioritized List of Health Care Services through the line on the list funded by the Oregon State Legislature as of January 1, 2012.
 - i. The benefits table in paragraph 0(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, in Attachment D 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	✓

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

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 as described in the State Plan

***Limited Vision coverage as described in the State Plan

e. Cost Sharing under OHP Plus

- i. For OHP Plus, individuals may be liable for nominal copayments. No copayment liability will be imposed on 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. Breast and Cervical Cancer Treatment Program (BCCTP)

- a. The Breast and Cervical Cancer Treatment Program (BCCTP), formerly known as BCCM, provides medical assistance to women under the age of 65 who have been screened and diagnosed through the Breast and Cervical Cancer Treatment Program

(BCCTP) and found to need treatment for breast or cervical cancer, or specific precancerous conditions, and are receiving such treatment. Such individuals are uninsured or underinsured with respect to necessary treatment.

- b. Women determined to be eligible for BCCTP (Population 21 in Attachment D) will be enrolled on the Oregon Health Plan for the duration of their treatment.

- c. BCCTP Presumptive Eligibility
 - i. Any licensed health care provider qualified to diagnose cancer or pre-cancerous conditions can determine presumptive eligibility under the BCCTP
 - ii. Presumptive eligibility provides immediate, temporary coverage for women who appear to meet basic eligibility criteria.
 - iii. Presumptive coverage lasts approximately a month before full determination of coverage through OHP.

- d. Eligible individuals remain eligible for a period of 12 months. At the end of the 12 months:
 - i. A redetermination application is sent to the client;
 - ii. The client's provider verifies if patient still requires treatment and submits verification to OHP;
 - iii. If the client still needs treatment, coverage is extended for additional year;
 - iv. Not have creditable health insurance to cover her treatment; and
 - v. Be in need of treatment for breast or cervical cancer, including qualifying precancerous conditions.

22. **Premium Assistance.** As of January 1, 2014, individuals who are currently enrolled in premium assistance under FHIAP or Healthy Kids ESI (Demonstration Populations 14, 16, 17, 18 and 20), and remain eligible for the Medicaid or CHIP state plan will be seamlessly enrolled in coverage through Medicaid or CHIP and will be enrolled in a CCO. Individuals currently receiving premium assistance who do not appear to be eligible under the approved Medicaid or CHIP State plans based on an initial assessment will be afforded a full eligibility determination prior to termination. Individuals denied Medicaid or CHIP eligibility will have their information electronically transmitted to the State Affordable Insurance Exchange (or other insurance affordability program as appropriate) to be treated as an application for eligibility and benefits through the Exchange.

a. **Overview of Premium Assistance Options**

- i. **Family Health Insurance Assistance Program (FHIAP)** (Populations 12, 14, 16, 17, and 18 in Attachment D). The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA), administers FHIAP. This premium assistance program provides subsidies to help families and individuals with income from 0 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. Children eligible for FHIAP have the choice between FHIAP and direct State Plan coverage.
- ii. **Healthy Kids Employer Sponsored Insurance (ESI)** (populations 16 and 20 in attachment D). Healthy Kids ESI provides child only premium assistance for available employer sponsored insurance (ESI) for families with children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL; and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI.
- iii. **Oregon Medical Insurance Pool (OMIP)** Oregon operates a high-risk medical insurance pool for individuals denied coverage for pre-existing medical conditions. Effective with the implementation of the ACA, and with the implementation of the Oregon Health Insurance Exchange (ORHIX), individuals eligible for OMIP will be transitioned to coverage under the ORHIX. Some individuals enrolled in OMIP are eligible for Medicaid or CHIP, and will be transitioned to coverage under those programs.

b. **Eligibility**

- i. **FHIAP through December 31, 2013.** 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 in Attachment D). Premium assistance can be used for employer-sponsored insurance (ESI) or individual health insurance. Eligible participants include: 1) Families (including parents), 2) childless adults, and 3) children (populations 14 and 16 in Attachment D) 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 with children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in

ESI. (Populations 16 and 20 in Attachment D). These children apply for coverage through DHS or OHA and voluntarily choose to receive subsidies for ESI. Children with income above 200 up to and including 300 percent of the FPL also have the option of electing coverage under the CHIP State plan through Healthy KidsConnect (population 22 in Attachment D).

c. Enrollment for Children:

i. FHIAP.

1. **Enrollment through FHIAP Reservation List Process.** Children from zero up to and including 200 percent FPL may elect to receive premium assistance for individual health insurance or ESI (populations 14 and 16 in Attachment D). 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.

ii. **Healthy Kids.** Alternatively, children with family incomes from 0-200 percent of the FPL may receive direct coverage under the CHIP State plan by applying for Healthy Kids through OHA and 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. These children can switch between direct coverage and FHIAP at any time.

1. **Healthy Kids ESI.** Children who have been found eligible for Healthy Kids direct coverage may choose premium assistance under Healthy Kids ESI instead. These children 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 Healthy Kids 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 or OHA refers the child to OPHP for enrollment and subsidy payment.

iii. **Healthy Kids Connect.** Children with family incomes above 200 and up to 300 percent of the FPL apply for coverage through OHA or DHS for eligibility for direct coverage under the CHIP State plan. The child may elect such coverage, or may elect Healthy Kids ESI premium assistance, if employer sponsored insurance is available, 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 Attachment D in FHIAP and Population 20 in Attachment D in Healthy Kids ESI relative to OHA 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 in Attachment D) 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, with priority for OMIP applicants, and then 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 in Attachment D) must be periodically notified that they may choose direct coverage under the State plan 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 in Attachment D) applying for FHIAP will receive written information explaining the differences in benefits, cost sharing and other provisions between 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. Children in families with income from above 200 up to and including 300 percent of the FPL are eligible for Healthy Kids ESI and under the CHIP State plan. 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 all age-appropriate immunizations (in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), well-baby, well-child services and emergency services for Title XXI eligible children will be covered, regardless of whether the health insurance coverage includes such coverage. The State shall provide information as to where children may receive immunizations without charge 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. **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:
 - 1. Is currently enrolled in the OHP;
 - 2. Was enrolled in the OHP within the last 120 days;
 - 3. Is a former FHIAP member;
 - 4. Has enrolled in a creditable health insurance plan while on the reservation list.

- a. Must have met the two-month period of uninsurance immediately prior to enrolling in the creditable health insurance plan;
- 5. Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700 - 735.714;
- 6. Has a military health insurance plan;
- 7. Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list;
 - a. Must have been without any creditable health insurance coverage for two consecutive months immediately prior to becoming insured under the group plan.
- 8. Has recently become unemployed and lost health insurance coverage as a result;
- 9. Has lost health insurance coverage while still employed (e.g. reduction in hours, employer stops providing coverage, etc); or
- 10. Is an OMIP member or an applicant to OMIP.
- vii. The State must establish and maintain procedures that will:
 - 1. Ensure that children who enroll in premium assistance are enrolled in creditable coverage;
 - 2. Ensure the consent of the responsible adult family member to receiving premium assistance under FHIAP instead of coverage through Medicaid or CHIP;
 - 3. 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;

4. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in individual or ESI coverage with premium assistance (if appropriate) and the individual's/family's share of the premium is being paid;
 5. Require eligible participants to immediately notify the State if they change or terminate their individual or ESI coverage under premium assistance (if appropriate);
 6. Ensure that the total amount of premium subsidies provided to an individual or family does not exceed the amount of the individual or family's financial obligation toward their coverage (if appropriate);
 7. Provide for recovery of payments made for months in which the individual or family did not receive individual or ESI coverage with premium assistance; and
 8. Provide for a redetermination of eligibility at least once every 12 months.
- 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 in Attachment D), 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.
 1. **Administration of changes to the FHIAP and Healthy Kids ESI benchmark** are through the Office of Private Health Partnerships (OPHP), which is within the Oregon Health Authority (OHA). 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.
 2. 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
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 Serves 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
Dental*	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 State must wrap-around dental coverage (as specified in 2103(c)(5) of the Act) for children in employer sponsored insurance plans that do not offer dental coverage in either FHIAP or Healthy Kids ESI.

i. Premium Assistance Levels

- i. Premium Assistance Levels.** FHIAP and Healthy Kids ESI premium assistance 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 premium assistance amount 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. Premium assistance 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 in Attachment D). 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 in Attachment D) 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 OHA 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 in Attachment D the State may lower the FPL used to determine eligibility; and/or suspend eligibility and/or intake into the program; or discontinue subsidies.
 - 1. 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.
 - 2. 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.
 - 3. 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.

4. All children (including Medicaid and CHIP eligible children in demonstration populations 3, 4, 5, 6, 7, 8, and 16 in Attachment D) and certain adults (populations 1, 2, 6, 7 and 8 in Attachment D) 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. **Limitations on the use of the Reservation List.** 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 paragraph 65.
 - 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. Enrollment 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:
 - 1. FHIAP's (Populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies);
 - 2. OHA direct coverage (Populations 1 through 11 in Attachment D) 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:
 - 1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.
 - iii. OPHP will monitor program expenditures for HK ESI (Population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.
 - 1. OPHP will report average aggregate cost sharing for HK ESI plans (Population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).
 - 2. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.
 - 3. This information will be provided in the State's annual report as specified in paragraph 65 as well as progress toward this goal in quarterly reports referenced in Attachment A.

V. DELIVERY SYSTEM TRANSFORMATION

Description of the pre-Health System Transformation Managed Care Delivery System

23. Pre-Health System Transformation Delivery Systems for OHP Plus and OHP

Standard. The majority of health care services under OHP Plus and OHP Standard are provided through a managed care delivery system. The managed care entities (MCEs) 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 managed care services have been delivered through the entities in Table 1. Once the health system transformation has been fully implemented the current managed care providers will be replaced by the Coordinated Care Organizations.

Table 1. Existing Care Delivery Systems

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Fully Capitated Health Plan (FCHP) (a managed care entity)	An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient hospitalization. Oregon contracts with FCHPs throughout the State to provide health care services to Oregon Health Plan members.	FCHP contract ends if the FCHP reorganizes as a CCO in a particular service area.	No new FCHP contracts after July 1, 2014.
Physician Care Organization (PCOs) (a managed care entity)	An organization contracted to provide physical health services, excluding payment for inpatient hospitalization.	The two PCO contracts will end if they join a CCO in the PCO service areas.	No new PCO contracts after July 1, 2014.
Mental Health Organizations (MHOs) – (a managed care entity)	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	MHO contract ends if the MHO reorganizes as, or joins, a CCO in a particular service area. MHOs will continue to serve enrollees currently FFS for physical health care until	No new MHO contracts after July 1, 2014.

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
		11/1/12. After that date, MHO contracts will end.	
Dental Care Organizations (DCOs) – (a managed care entity)	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	CCOs will contract with DCOs in the CCO service area, but DCOs must be integrated into CCOs by July 1, 2014.	CCO/DCO contracts will be executed by July 1, 2014.
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.	Some PCMs will continue to exist for the small FFS population remaining. The state will be working with PCMs to meet PCPCH requirements.	Ongoing and parallel to CCO timelines.
Fee-For-Service/ Open Card	The OHP participants may also receive services through the fee-for-services delivery system. The OHP participant that receives service through FFS may be served through a PCPCH.	FFS open card will be maintained only for small number of exempted or excluded populations or those outside CCO service areas.	Ongoing
Patient Centered	The PCPCHs provide	The PCPCHs are	Ongoing

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Primary Care Homes (PCPCH)	comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services.	optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system.	Transition over 3-5 years as more PCPCHs become certified

Health System Transformation Transition

24. The State will transform its delivery system through a shift to the delivery of care from current specialized MCEs to Coordinated Care Organizations (CCOs) beginning in August 2012. Initially, CCOs will be required to provide both medical and behavioral health services (formerly provided under different MCEs). Dental services must be merged into the CCO by July 2014. The State’s contracting with the CCO will result in the phase out of new Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), and Mental Health Organization (MHO) contracts by July 1, 2014 and CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. The CCOs initially will be phased into the delivery system over four monthly cycles (or “waves”) beginning in August 2012 and ending in November 2012.

a. Transition of OHP Populations to CCOs

- i. Existing enrollees of an MCE that has transitioned to a CCO will be given a 30 day notice and transitioned (rolled over) to the new CCO when certification and contracting is complete. This roll over will include currently enrolled tribal members and dual eligibles, who will be able to opt-out if they wish. Existing members who are receiving services from out-of-area or non-participating providers will be moved to a CCO when their MCE transitions. For these members, the CCO will be expected to cover out-of-network or non-participating provider services authorized by the member's care team, Medical Director of the MCO or the Medical Director of the Division of Medical Assistance Programs, for a transitional period until the CCO establishes a relationship with the member and is able to develop a medically appropriate care plan.
 - 1. An MCO transitioning to become a CCO in any of the four initial contracting waves will retain its existing enrollees and those enrollees will be

transitioned (rolled over) to the new CCO when certification and contracting is complete.

2. For an MCO not transitioning to become a CCO in any one of the four waves, enrollment of existing members will continue in the plan until the member chooses another plan as described below, or until the OHA determines on a case-by-case basis that members should be transitioned to other plans serving the geographic area.
- ii. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.
 1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.
 2. All existing MCEs from Table 1 in paragraph 23 will be closed to new enrollment once sufficient capacity is determined to exist in the CCO(s) serving the area. If CCOs do not have sufficient capacity, new members may be enrolled only in MCOs on the path to becoming a CCO in one of the four waves until capacity in those plans is reached, then can be enrolled in any remaining MCOs.
 - iii. Individuals who are currently in FFS for physical health, other than dual eligibles and tribal members, will receive a 30 day notice and be required to enroll in CCOs by November 1, 2012 where sufficient capacity exists, and will be given their choice of plan.
 1. Members not choosing a plan will be auto-assigned to a plan through an auto-enrollment process.
 2. For members who are enrolled in an MHO for mental health services but otherwise receive physical health services through fee for service, if a CCO becomes operational in their area prior to November 1st, their mental health coverage will be through that CCO until they are enrolled in a CCO for both physical and mental health services in November.
 - iv. Tribal members and dually eligible individuals are both populations that must make an affirmative voluntary choice for CCO (and existing MCE) enrollment (i.e., cannot be auto-enrolled).
 - v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

- vi. OHA is planning member transition strategies for FFS members with special considerations:
 1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:
 - Care management requirements based on the beneficiary's medical condition
 - Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations
 - Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services)
 - Availability of medically appropriate medications under the CCO formulary
 - Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team
 2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

Description of Delivery System Transformation

25. **Definition and Role of Coordinated Care Organizations.** CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the State. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this Demonstration. CCOs will provide a governance structure to align the specialized MCE services under one managed care organization. CCOs will partner with OHA to further the State's implementation of PCPCH and utilization of Non-Traditional Health Workers (NTHWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

- a. **CCO Criteria.** The CCOs are required to meet the following criteria:
 - i. **Governance and Organizational Relationships.**

1. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least two members from the community at large to ensure that the organizations decision making is consistent with the community members' values. .
 2. Community Advisory Council (CAC). The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.
 3. Clinical Advisory Panel. The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.
 4. Partnerships. The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.
 5. Community Health Needs Assessment. Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The State encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.
- b. **CCO quality and access measurement.** CCOs will be accountable for metrics for quality and access as described in Section VII and Attachment E, including measures to track progress in the quality improvement focus areas, measures to track quality broadly, and measures to track access. Specific measures, timeframes, and CCO reporting

requirements will be determined by the state and approved by CMS during the supplemental 120-day planning period.

- i. **Menu-set of CCO quality improvement focus areas.** OHA will ensure that each CCO will commit to improving care in at least 4 of the following 7 focus areas, which have the significant potential for achieving the demonstration's goals of improving the patient experience of care, improving population health, and reducing per capita Medicaid expenditure trend. Three of these four projects may serve as a CCO's Performance Improvement Projects in accordance with 42 CFR 438.358 and 438.240. Attachment E provides further details on each of these focus areas. The State and CCOs may add to this menu of focus areas but should review Attachment E and provide a similar level of detail for anything not on the list below. The State will incorporate the PIP requirements into its CCO/MCE contracts within 120 days of the approval of the demonstration

1. Reducing preventable rehospitalizations.
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by "super-utilizers".
4. Integrating primary care and behavioral health.
5. Ensuring appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home model of care throughout the CCO network.

- c. **Health Information Technology (Health IT).** The CCOs are directed to use HIT to link services and core providers across the continuum of care to the greatest extent possible. The CCOs are expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

- i. Health IT:

1. CCOs must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information

exchanges. If providers do not currently have this technology, there must be a plan in place for adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

2. In order for CCOs to fully realize years 2-3 performance incentives, the State must require that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The related incentives must take into account the costs incurred in order to facilitate adoption and meaningful use of EHRs, as well as the existing incentives available to eligible providers.
3. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. The State must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.
4. All requirements must also align with Oregon's State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

d. **Innovator Agents and Learning Collaboratives.** State shall utilize innovator agents to act as a single point of contact between the CCO and the Oregon Health Authority. Innovator agents will be assigned to each contracted CCO by January 15, 2013. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the Demonstration's goals of improving quality and access while managing costs, within 120 days from the approval of the Demonstration amendment the State will:

- i. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.
- ii. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the State will plan and execute intensified innovator/learning collaborative interventions.
- iii. The information in (a) and (b) above will be incorporated into the CCO contracts by amendment.

26. **Alternate Delivery System.** The FFS delivery system applicable to some Demonstration populations will continue under the health system transformation.
27. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.
28. **Compliance with Managed Care Requirements.** The State must meet the requirements of 42 CFR Part 438 unless a requirement of part 438 has been identified in the waiver authorities for this Demonstration.
29. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**
- a. **Mandatory Enrollment.** The State may mandatorily enroll individuals served through this Demonstration in managed care programs to receive benefits pursuant to Sections – IV and V of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to 12 months. The Table below illustrates the mandatory and affirmative choice (i.e., ~~opt-in~~) populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given ²
1-11	Individuals of the identified populations other than those footnoted. ³	Mandatory; current FFS enrollees not transitioned for physical health until November 2012	Other CCO if available; MCO if no CCO in area; FFS with cause
21	Breast and Cervical Cancer Treatment Program Income: Up to 250% FPL	Not enrolled until November 2012, then Mandatory	Other CCO if available; MCO if no CCO in area; FFS with cause

² See (b) below for more information on disenrollment/plan change options and timelines.

³ Exceptions include individuals who are: dually eligible for Medicare and Medicaid, American Indian or Alaska Native who are permitted to enroll, but not mandatory. Current MCO enrollees will be rolled over to a CCO in November 2012, others may opt in. FFS populations who require special consideration (e.g., HIV/AIDs) will be transitioned in November 2012, after receiving individualized transition planning.

Population	Description	In/Out of CCOs	Disenrollment Options Given ²
	Resource Limit: None		
22	Targeted low income children up to 200 percent of the FPL who are eligible for direct services under the CHIP State Plan. Title XXI children ages zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP State plan (under Healthy KidsConnect)	Mandatory Out	Other CCO if available; MCO if no CCO in area; FFS with cause
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
22	Targeted low-income children from conception to birth with income from 0 up to 185 percent of the FPL who are eligible under the CHIP State Plan.	Optional	N/A
12, 14, 16-18, and 20	Individuals in FHIAP and Healthy Kids ESI	Out	N/A
1-11, 21 and 22	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid State	Individuals who are	Out	N/A

Population	Description	In/Out of CCOs	Disenrollment Options Given ²
Plan	receiving non-OHP Medicare (QMB, SLMB, QI)		
Medicaid State Plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid State Plan	Individuals who are Transplant Rx only	Out	N/A

b. **Disenrollment.** The information in the table is applicable to all managed care enrollees.

Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438.
Eligibility redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

30. **Network Adequacy and Access Requirements.** The State must ensure that any MCE and CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the State's quality strategy required by 42 CFR 438.204.

31. **Required Notice for Change in CCO Network.** The State must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network

adequacy. The State must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

32. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the State will implement contingency planning in consultation with CMS to assure enrollee continuity of care.

33. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10(f)(4), 42 CFR 438.6(i) and 42 CFR 431.20, the State may allow the use of electronic methods for the beneficiary and provider communications as required by:

- 42 CFR 438.10(b) – Special rule for mandatory enrollment states – timeframes for providing information;
- 42 CFR 438.10(e) - Information for potential enrollees;
- 42 CFR 438.10(f)(2), (3) and (6) - Right of enrollee to request and obtain information;
- 42 CFR 438.10 (g)(2) and (3) – Other plan information, including PIPs;
- 42 CFR 438.10(h)(2) and (3) - For PAHPs only - Other plan information, including PIPs;
- 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
- 42 CFR 438.102(b)(1)(ii) – state policies on excluded services.

a. The State may allow the use of such electronic communications only if:

- i. The recipient has requested or approved electronic transmittal;
- ii. The identical information is available in written form upon request;
- iii. The information does not constitute a direct beneficiary notice related to an adverse action or any portion of the grievance, appeals, hearings or any other beneficiary rights or beneficiary protection process; and
- iv. Language and alternative format accommodations are available.
- v. Please note: All HIPAA requirements apply with respect to personal health information.

34. **Transparency/Public Reporting.**

- a. The State must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).
- b. The state shall publish data regarding CCOs' performance on State-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the State's progress toward achieving the two primary goals of this demonstration.

35. **State Oversight of the CCOs.** The State Agency must have in effect procedures for monitoring the CCO operations, including, at a minimum operations related to the following: recipient enrollment and disenrollment; processing of grievance and appeals; violations subject to immediate sanctions, as set forth in sub part I of 42 CFR 438; violations of the conditions for FFP, as set forth in subpart J; and all other provisions of the contract.

VI. CAPITATION RATES AND PERFORMANCE MEASURES

36. **Principles for Payment Methods that Support the Three-Part Aim.** The State will employ the following concepts in its payment methods to CCOs:

- a. The State will transition to a payment system that rewards health outcomes improvement and not volume of services.
- b. The State will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services. The global budget will be phased in, but will eventually consist of two parts: 1) a capitated per member per month (PMPM) payment; and 2) a separate PMPM payment for services not included under the capitation rate.

Until January 2013, the global budget will include only capitated services (i.e., the first part above). After January 2013, the State will begin including additional services to the global budget (see Attachment F). These services may be included in the capitated portion of the global budget or in the separate PMPM payment methodology. The methodology for inclusion of additional services in the global budget will be mutually

agreed upon by the State and CMS and phased in over the course of the Demonstration. The State and CMS will finalize the methodology for inclusion of additional services within 120 days of this agreement.

No payment will be made for CCO enrollees to FCHPs, MHOs and, if dental services are included in the CCO benefit package, DCOs.

- i. Attachment F provides a proposed schedule of inclusion of additional services into the CCO global budgets. Initial CCOs approved August through December 2012 will be at risk for Lines 1-8 through a PMPM global budget. The state intends to add service lines 9-22 to CCO global budgets over the course the demonstration. While the intent is to include as many services as possible within the PMPM payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding these services to the global budget. Until services are added to the global budget either through the PMPM or another methodology, CCOs are not at risk for services other than 1-8 in Attachment F. If the state wishes to add any services included in lines 23-38 in Attachment F, the state will work with CMS to determine the most appropriate methodology for inclusion of the additional services within the CCO global budgets and amend the Section 1115 waiver if necessary.
- c. The CCO contract language will require the CCOs to consider alternative non-State Plan services (the constellation of these services includes services known as ~~in lieu of~~ “in lieu of services,” ~~substitute services~~ “substitute services,” “flexible services,” and ~~non-encounterable services~~ “non-encounterable services” and hereafter referred to as ~~flexible services~~ “flexible services” in order to capture the array of potential services). CCOs are always at liberty to offer any *additional* health-related services at their discretion, as allowed under 42 CFR 438.6(e). Since enrollees may need additional services that are not substitutes for State Plan services, which could ultimately improve the enrollee’s health, the CCOs should use this option as necessary.
 - i. The contract must not require specific, discrete service substitutions, but may require that the principle of ~~flexible services~~ “flexible services” (i.e., that CCOs look for more cost-effective services to replace or supplant the need for State plan services, as appropriate) be applied under the following circumstances:
 1. An enrollee’s request to have a State Plan service rather than a flexible service must be honored when medically necessary.

2. All flexible services will be health related however the CCO will have broad flexibility in creating the array of services to improve care delivery and enrollee health. The State will report on the non-State plan services provided through the CCO contracts, including the effectiveness of the services in deterring higher cost care.
 3. Flexible services will be accounted for in the administrative expenses part of the capitation rate. Although flexible service will not be included in the medical expenses portion of the capitation rate, utilization assumptions may be applied.
- ii. The CCO contracts may levy performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. I.e., the more creative the CCOs are with flexible service delivery, health outcomes will improve and growth in per capita expenditures will decrease.
1. As CCOs provide health care services that are more cost-effective than State Plan services (which is what the capitation rate is based on), the capitation per capita growth rate should gradually decrease over the waiver period. The State will offset the decrease in capitation per capita rate growth with additional incentives outside of the capitation rate.
 2. Over time, the per capita expenditure trend should be lower through decreased use of unnecessary and costly services. This will happen when: 1) Decreased utilization of unnecessary and costly services; 2) Financial reward of CCOs and their contracted providers for quality improvement, not volume of services; and 3) the health status of enrollees improves through coordination of care.
 3. Success will be measured by and incentives paid based upon: 1) decreased rate of per capita Medicaid expenditure growth; 2) increased patient satisfaction with, and involvement in, care planning and quality of care; and 3) overall population health improvement.
- d. In each year, the State and CCOs must track discrete services whether it is a State Plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate.

37. **Structure.** Capitation rates and incentives for the Coordinated Care Organizations (CCOs) for each demonstration year (DY) will be structured as follows:

a. Demonstration Year 11:

- i. Capitation rates. There will be no major changes in the currently approved rate-setting methodology for DY11.
- ii. Incentives and Withholds. There will be no incentive payments made to CCOs or amount withheld from the CCOs.
- iii. Special performance Standards. The State will apply special performance standards of timely and accurate data reporting in the first year.

b. Demonstration Years 12 through 15:

- i. Capitation Rate Withhold. The first quarter of DY 12 will include a 1-percent capitation rate withhold that will be returned to CCOs successful in DY 11 performance metrics which reward timely and accurate data reporting. A CCO that successfully meets the performance metrics of timely and accurate data reporting in DY 11 will receive the full capitation rate in this quarter. A CCO that does not meet the DY 11 performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will determine the parameters for the special performance standards of timely and accurate data reporting within 120 days of this agreement.
- ii. The State will have an additional 120 days after the agreement is in effect to address the details of DYs 12-15 so long as it is within the following parameters and subject to CMS approval:
 1. Bonus Incentive Pool. The State will establish a separate bonus/incentive pool outside of the capitation rates (i.e., in addition to any capitation rate withholds). Incentives must be designed to reduce costs and improve health care outcomes. When developing the bonus pool, the State will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing.

- a. The State will alert the CCOs that the bonus incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole bonus incentive pool amount will be at risk. The State will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance. Within 120 days of the Demonstration approval, the State will submit and CMS will approve the specific requirements. The State will amend its CCO contracts to incorporate the changes immediately following the 120-day period.
2. CCO Provider Agreements. Incentives must be correlatively reflected in the CCO/provider agreements to insure that the incentives are passed through to providers to reflect the arrangement with the State-CCO contract.
- iii. Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The State will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

VII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

38. **Overview.** Improving access and quality is a key component of the State health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.
39. **Metrics and Scoring Committee.** The State's strategy for a robust measurement includes the newly established Metrics and Scoring Committee. The Committee will review data and the relevant literature, determine which measures will be included in the CCO incentive program, and establish the performance benchmarks and targets to be used in this incentive program. The Committee will endorse/develop specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. A transitional Metrics and Scoring Committee recommended a set of metrics for the first

program year, which were described in CCO RFA contracts. Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.

40. **Additional Quality Measures and Reporting at the CCO Level.** CMS developed an additional list of requirements for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations. This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this Demonstration. The CCOs will be required to collect and validate data and report to the State on the metrics listed in this section, which may be revised or added to over time as the demonstration matures, but these metrics will remain constant for the first 2 years of the demonstration. CMS also encourages the CCOs to report on the core set of performance measures for children and adults in Medicaid and CHIP.

a. **Metrics to track quality improvement focus areas:** Pursuant to paragraph 25.b.i), the State and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)

b. **Core set of quality improvement measures.** The initial core measures will track the following:

- i. Member/patient experience of care (CAHPS tool or similar);
- ii. Health and functional status among CCO enrollees;
- iii. Rate of tobacco use among CCO enrollees;
- iv. Obesity rate among CCO enrollees
- v. Outpatient and emergency department utilization;
- vi. Potentially avoidable emergency department visits;
- vii. Ambulatory care sensitive hospital admissions;
- viii. Medication reconciliation post discharge;
- ix. All-cause readmissions;
- x. Alcohol misuse-screening, brief intervention, and referral for treatment;
- xi. Initiation & engagement in alcohol and drug treatment;
- xii. Mental health assessment for children in DHS custody;
- xiii. Follow-up after hospitalization for mental illness;
- xiv. Effective contraceptive use among women who do not desire pregnancy;
- xv. Low birth weight;
- xvi. Developmental screening by 36 months; and
- xvii. Difference in these metrics between race and ethnicity categories;

- c. **Access improvement measures based on CCO data.** The State and CMS will identify and agree to additional access measures by 120 days after the approval of this demonstration planning period. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.
- i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
 - ii. Percentage of adults with any outpatient visit.
 - iii. Percentage of adults with a chronic disease w/any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
 - iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.
 - v. Percentage of children with at least one dental visit.
 - vi. Fraction of physicians (by specialty) ‘participating’ in the Medicaid program.
 - vii. Change in the number of physicians (by specialty) participating in Medicaid
 - viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
 - ix. Percentage of CCO enrollees with access to a PCPCH.
- d. **Access improvement measures based on state survey data.** The State will identify and CMS will approve additional access measures, particularly measures based on survey data, by 120 days after the approval of this demonstration planning period. Additional survey-based measures could include:
- i. Percent of beneficiaries with a usual source of care.
 - ii. Percent of beneficiaries with a preventive visit in past year.
 - iii. Percent of beneficiaries with a dental visit in past year.
 - iv. Percent of beneficiaries with any unmet needs.
 - v. Percent of beneficiaries delaying/deferring care due to cost.
 - vi. Percent of beneficiaries delaying/deferring care due to lack of available provider.
 - vii. Percent of beneficiaries delaying/deferring care due to provider office being closed at time of illness.
 - viii. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

41. **Utilization of new services.** The State and CCOs must track discrete services whether it is a State Plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement.
42. **Quality and Access Data Reporting from the State to CMS.** In accordance with paragraph 7864, ~~Monitoring to Assure Progress in Meeting Demonstration Goals,~~” the State will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the State will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 120 days of the Demonstration approval, the State will submit and CMS will approve a reporting format.
43. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**
- a. **Statewide quality, access, and expenditure monitoring and analysis.** The State, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The State must report to CMS any CCO issues impacting the CCO’s ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights
 - b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the State shall intervene promptly within 30 days of identifying a concern, with CMS’ technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.
 - c. **Additional actions taken if goals are not achieved.** If the interventions undertaken pursuant to paragraph 43.b do not result in improved performance in identified areas of

concern within 90 days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the State placing the CCO on a corrective action plan. The State must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

44. **EQRO.** The State is required to meet all requirements found in 42 CFR 438, subpart E. The State will need to amend its current EQRO contract to require the reporting of outcomes information in the annual technical report related to performance measures and performance improvement projects. The State should generally have available its final EQR Technical Reports to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)]. In the first year of the transition to the CCO system and to a modified EQRO contract, CMS will use the quality and access data from the quarterly reports as identified in paragraph 42 to satisfy regulatory requirements.
45. **State Quality Strategy.** In accordance with CMS regulations, the State is required to submit a written strategy for assessing and improving the quality of managed care service offered by all managed care entities. This written strategy (also referred to as the “quality strategy”) must meet all of the requirements found in 42 CFR 438, subpart D. Before implementing a final, approved quality strategy, the State is required to submit a draft quality strategy to CMS for approval within 120 days of the approval date of the Demonstration. The State will submit a revised strategy to CMS within 60 days, whenever significant changes are made. The State will submit annual reports to CMS on the implementation and success of the strategy, by means of the annual EQRO technical report or a separate annual report that assesses the implementation and effectiveness of the quality strategy.

VIII. CALCULATING THE IMPACT OF HEALTH SYSTEMS TRANSFORMATION AND REDUCTIONS IN DESIGNATED STATE HEALTH PROGRAM FUNDING

This section establishes the parameters by which the State and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on a quarterly and annual basis as specified in paragraph 64.

There are three levels of baseline and actual expenditures that the State must calculate and provide to CMS that will be measured and monitored annually under this demonstration. These levels are:

- Level 1: the per member per month expenditure to the State to *purchase* identified global budget services for populations to be mandatorily enrolled in CCOs and voluntarily enrolled CCO populations,
- Level 2: the per member per month total expenditure to the State to *purchase* services across all Medicaid service expenditures for populations that are mandatorily required to enroll in CCOs and voluntarily enrolled CCO populations regardless of whether the services are included in CCO global budgets, and
- Level 3: The per member per month total expenditure to the State to *provide* care under Health System Transformation in Oregon.

46. The following section summarizes the specific populations, expenditures, and other variables that will be included in calculations of each of the expenditure levels described above.

a. **Level 1: Global Budget Expenditures.**

These expenditures are for services identified in Attachment F for all individuals enrolled in eligibility categories that are required to enroll in CCOs (mandatory populations) and for individuals that voluntarily enroll in CCOs that are in non-mandatory enrollment populations (voluntary populations). Expenditures would also include any incentive payments, shared savings payments made to CCOs as well as wrap-around or supplemental payments for services identified in the global budget and provided to these populations. This expenditure level is the level against which the health care cost trend targets and the associated funding consequences described in paragraph 54 will be based.

b. **Level 2: Medicaid Program Service Expenditures**

These expenditures are for all Medicaid services provided to all individuals enrolled in mandatory eligibility categories as well as those individuals enrolled in voluntary populations who voluntarily enroll in CCOs. This expenditure level includes all payments described in level 1 plus all other Medicaid payments for services provided under the demonstration or the State plan to individuals described in level 1 during a demonstration year. These additional expenditures would include services such as long term care services that are not included in the global budget service package but are provided to individuals described in level 1.

c. **Level 3: Medicaid Program Costs for Health System Transformation**

This expenditure measure will capture total costs to support Health System Transformation (HST) and will include all costs in level 1 plus all costs that the State incurs for supporting HST including activities such as learning collaboratives, innovation agents, and other activities performed or contracted by the State to implement and operate HST.

47. **Calculating Baseline Expenditures.** The baseline expenditures to the State without Health Systems Transformation of these services will be developed using expenditure information from 2011 for the full calendar year. The costs will be developed for each level of spending for each eligibility group. These baseline costs will be transformed into aggregate per member per month costs based on total member months in 2011. The groups are:

Population	Enrollment
Children	Mandatory
Non-disabled Adults	Mandatory
Disabled Adults	Mandatory
Dual Eligibles	Voluntary

The baseline PMPMs for each level will be developed as follows:

- a. Level 1: The actual baseline PMPM will include all costs for global budget services plus all wrap-around payments for all populations whose enrollment is mandatory or voluntary (as defined in Table 2 in paragraph 29). The base costs for global budget services will be divided by the total applicable member months to create an aggregate PMPM.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the State and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

- b. Level 2: The actual baseline PMPM will include all level 1 costs plus all other Medicaid service expenditures attributable to 2011 for all individuals in both mandatory and voluntary populations. The total base costs for global budget services will be divided by the total applicable member months.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the State and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

- c. Level 3: The actual baseline PMPM will include all level 1 costs by eligibility group and for the base year, should not differ from Level 1 expenditures as the additional costs in this category is expenditures supporting health system transformation.

The baseline PMPM in Level 1 will be the without Health System Transformation (HST) costs. The trend rate applied to the aggregate PMPM, which is based on the President's Budget estimates of the national rate of growth in Medicaid expenditures on a per member per month basis, is 5.4% for each year in the demonstration. If within the 120 day period following approval of the demonstration, the State provides analysis and data demonstrating that Oregon's trend differs substantially from this national average, and the Chief Actuary of CMS determines the difference to be valid and calculated reasonably and in accordance with general actuarial standards of practice, CMS will adjust this trend rate.

The PMPM calculation will be performed for each level (1, 2, and 3) described above in the aggregate.

48. Calculating Actual Expenditures under Health System Transformation. This measurement is based on actual DY expenditures for services and supports under HST. Actual HST PMPM expenditures will be calculated as follows:

- a. Level 1: The actual HST expenditure PMPM will include all costs for global budget services plus all wrap-around payments.

For the mandatory populations, costs for global budget services will be included regardless of whether the CCO directly provided the services or not and whether or not individuals were enrolled in a CCO.

For voluntary populations, the costs for global budget services will be included regardless of whether the CCO directly provided the services or not. Expenditures and member months for individuals in the voluntary group will be included in this calculation only if they were enrolled in a CCO.

The State will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory populations and voluntary populations if they were enrolled in a CCO.

- b. Level 2: The actual HST PMPM will include all Level 1 costs plus all other Medicaid service expenditures during the DY. For the mandatory populations, the total level costs will include both global budget services and all other Medicaid services provided to individuals in the mandatory eligibility groups.

For voluntary populations, costs will include all Level 1 costs plus all other Medicaid service expenditures during the DY only for individuals actually voluntarily enrolled in

CCOs. Individuals in the voluntary group will contribute their expenditures only if they were enrolled in a CCO.

The State will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory and voluntary populations.

- c. Level 3: The HST PMPM will include all Level 1 costs by eligibility group and all costs incurred by the State for expenditures to support HST. The costs will include activities such as learning collaboratives, innovator agents, the quality and access metrics committee, and other administrative support the State may provide to facilitate the implementation and operation of CCOs and HST. The State will submit and CMS will approve within 120 days after the date of approval of the demonstration the activities and costs that will be included in the HST support expenditure category.

For mandatory and voluntary populations, the HST calculation will include Level 1 aggregate expenditures plus aggregate, identified HST support expenditures divided by total Level 1 mandatory and voluntary member months.

49. **Calculation of Trend Reduction Targets:** The State must beginning immediately following DY 12 to annually demonstrate the savings achieved under HST using the without HST PMPM and the HST PMPM for Level 1 expenditures each DY. The savings requirements and penalties are described in paragraph 54.

The PMPM savings percentages will be reported for each eligibility group and in the aggregate, although the savings reduction requirement will be applied only to the aggregate with and without HST expenditures. The aggregate HST PMPM must be below:

- a. the 5.4% without HST trend rate by 1 percentage point in DY 12 (i.e. aggregate PMPM expenditures in DY 12 must be no more than a 4.4% increase over DY 11 aggregate without HST PMPM expenditures).
- b. the 5.4% without HST trend rate by 2 percentage points in DY 13, 14 and 15 (i.e. aggregate PMPM expenditures in DY 13 must be no more than a 3.4% increase over DY 12 aggregate without HST PMPM expenditures).

50. **Return on Investment.** Annually, CMS will analyze the total return on investment in HST. The State must provide information (as part of the reporting requirements in paragraph 64) on total new federal funds claimed as DSHP as well as federal funds claimed using State funds repurposed as a result of DSHP relative to health savings achieved under the health transformation process. Elements in the analysis will include:

- a. New federal funds drawn as match against DSHP programs.

- b. New federal funds drawn as a result of DSHP. Under the State's proposal, this includes all federal funds drawn associated with State funds redirected from DSHP except DY1 rate stabilization.
- c. Savings identified in the total cost of purchasing care in level 3 as described above (the total investment in HST).

51. Evaluating Impact on Medicare and Medicaid Expenditures for Dual Eligibles. In addition to expenditure estimates in paragraphs 47, 48, and 49, CMS and the State will examine total expenditures on individuals who are dually eligible for Medicaid and Medicare who are enrolled in CCOs.

52. Measurement of Quality and Access Under the Demonstration. The State will also monitor and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.

Within 120 days of approval of the demonstration, the State will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the State will use to monitor quality of and access to care for individuals enrolled in CCOs and for the State's Medicaid population as a whole. The State's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). State quality and access reporting will take place on the same timeframes as the State's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

53. Deliverables to be Negotiated Within 120 Days Post Approval: Within 120 days of approval of the demonstration, CMS and the State will:

- a. Finalize the benefit package for the global payment Level 1 analysis during the demonstration period (Attachment F).
- b. Finalize the parameters of the total cost of care for levels 2 and 3 by identifying all payments and costs subject to inclusion in the costs of care calculation.
- c. Finalize the annual per capita amount for the baseline period.

- d. Finalize safe harbor language to limit risk to the state for increases in FQHC wrap-around payments for reasons that are not within the state’s control for the purposes of Level 1 calculations. Valid reasons would include an increase in FQHCs in the state relative to the base year or changes in scope of service that actually effect the PPS rate.
- e. Finalize a methodology for the treatment of long term care services and supports (LTSS) expenditures.
- f. Finalize the return on investment formula template and the per capita reporting templates.
- g. Finalize the calculation of cost shifting using Medicaid uncompensated care (shortfall) using DSH audit information.
- h. Finalize the timing of and reporting format of the annual expenditure and savings calculations.
- i. A plan for specific quality and access measures that the State and CMS will use to monitor access and quality during the demonstration, as well as methods for such measurement and reporting timeframes.
- j. CMS will review, discuss with the State, and approve all of the above deliverables within 30 days after the 120 day period.

54. Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets

This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

- a. **Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates.** CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Table 3: Per Capita Expenditure Growth Reduction Targets and Associated DSHP Expenditure Authority Reductions for Failure to Meet Targets

Demonstration Year	Per Capita Expenditure Growth Reduction Target (measure following DY	Reduction in DSHP Expenditure Authority (reduce succeeding DY’s
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	close)	DSHP expenditure authority)
DY11	NA	NA
DY12	1 percentage point	\$54 million
DY13	2 percentage points	\$68 million
DY14	2 percentage points	\$68 million
DY15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the State in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the State has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

- b. **Earn Back Option.** For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:
- i. If the State undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year *and* significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.
 - ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the State undertakes a corrective action plan to achieve improvement and CMS determines that the State has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.
 - iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

IX. DESIGNATED STATE HEALTH PROGRAMS

55. **Designated State Health Programs (DSHP).** To support the goals of health system transformation, the State may claim FFP for the following State programs subject to the annual limits and restrictions described below through June 30, 2017, unless otherwise specified. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment G. Subject to approval by the federal Office of Management and Budget, these expenditures can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of paragraph 54.

56. **Aggregate DSHP Annual Limits** – Expenditure authority for DSHP is limited to \$704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by year as follows:

Table 4: Aggregate DSHP Annual Limits

Demonstration Year	Time Period	Annual Limit on FFP
DY 11	07/1/12-06/30/13	\$230 M
DY 12	07/1/13-06/30/14	\$230 M
DY 13	07/1/14-06/30/15	\$108 M
DY 14	07/1/15-06/30/16	\$ 68 M
DY 15	07/1/16-06/30/17	\$ 68 M

57. **Restrictions on DSHP Programs.** Approved Designated State Health Programs for which FFP can be claimed are outlined below subject to the following funding limits by the four categories listed below. Prior to claiming funding for these programs, the State will submit and CMS will approve a DSHP claiming protocol. The State is not eligible to receive FFP until the protocol is approved. Upon CMS approval of the claiming protocol, state is eligible to receive FFP for the approved DSHP program expenditures beginning July 5, 2012.

Table 5. Limits on Allowable Designated State Health Programs

Expenditures by Type of Designated State Health Programs:	DY 11	DY 12	DY 13	DY 14	DY 15	Total
Oregon Medical Insurance Program	93	93	0	0	0	186
Workforce Training	69	69	40	0	0	178
Gero-Neuro	8	8	8	8	8	40
Other CMS Approved*	60	60	60	60	60	300
Total	230	230	108	68	68	704

*See Table 6 for all approved programs.

- a. **Oregon Medical Insurance Program.** The State may claim FFP for expenditures related to the Oregon Medical Insurance Program only for DYs 11 and 12.

- b. **Workforce Training.** To promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the development of the health care workforce in the State and to the extent that such education promotes the rate of Medicaid participation among Oregon providers, the State may claim FFP for health workforce training programs and related supports at Oregon Health and Science University (OHSU), Oregon University System (OUS), and community colleges as follows; Blue Mountain, Clatsop, Linn Benton, Rogue, Umpqua, Central Oregon, Columbia Gorge, Mt Hood, Southwestern, Chemeketa, Klamath, Oregon Coast, Tillamook Bay, Clackamas, Lane, Portland, Treasure Valley. The State may only claim FFP for workforce training DSHP programs in DYs 11-13. The annual limit the state may claim FFP for workforce training programs is limited to direct and indirect costs and shall not exceed \$69 million in each of DYs 11 and 12 and \$40 million in DY 13.
 - i. **Loan Repayment:** To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the State shall commit to funding a primary care provider loan repayment program, with the following conditions:

By July 1, 2013, the State shall establish an annual funding level of \$2,000,000 to provide assistance to providers who make written commitments to serving Medicaid populations in rural and underserved areas. If the State is unable to establish funding for this program at the amount specified in this term, the State's Workforce Development state designated health program expenditure authority must be reduced. The DSHP Workforce Development funding must be reduced by 25 percent of the difference between the \$2,000,000 and the amount that the State is able to reinstate for the loan repayment program for Demonstration Years 12 and 13.

 - ii. **Training for Community Health Workers:** The State, through its Community Colleges, shall establish Community Health Worker curriculum that meets the core training elements established by the Oregon Health Policy Board. The State shall train 300 additional Community Health Workers by December 2015.

 - iii. **Increased Workforce/Provider Capacity.** The State must track the number of Medicaid primary care providers (including nurse practitioners, etc.). The State must submit to CMS within 180 days of the date of the demonstration amendment approval letter, a report detailing the number and types of primary care providers that are currently seeing Medicaid beneficiaries in the State of

Oregon. In addition, the State must track where the graduates of these Educational Institutions are working and whether they become Medicaid providers beginning with DY 12 Quarterly and Annual Reports.

- c. **Gero-Neuro.** The State may not begin claiming FFP for the Gero-Neuro program until the State begins the process to recertify the facility as an IMD meeting the inpatient hospital requirements as set forth in 42 CFR section 440.140 which include by reference requirements for the hospital conditions of participation at 42 CFR 482. Medicaid and CHIP citizenship rules apply as a condition for receiving FFP.
- d. **Other CMS Approved DSHP.** For DYs 11-15, the State may claim FFP for expenditures related to state health programs specified in the “other” category of Table 6 in paragraph 58, subject to a 4.2% reduction on an annual basis. To the extent that the State identifies other programs in this category that support the health care needs of low-income, uninsured Oregonians, the State may submit to CMS for review and approval additional program expenditures for which expenditure authority may be provided. In the event of a shortfall in the “other” category, CMS will consider additional expenditures for OMIP if the State is able to document such expenditures. For any additional OMIP or other expenditures, the State must obtain prior CMS approval for the methodology used to claim any such additional expenditures, subject to the aggregate limit described in Table 5. Once all relevant approvals are obtained, CMS and the State will update the DSHP claiming protocol (Attachment G).

58. **Specified Designated State Health Programs (DSHP).** The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and limits described in section XIII of the STCs.

Table 6.

DSHP
OTHER
Non-Residential Adult (AMH1)
Child and Adolescent (AMH1)
Regional Acute Psychiatric Inpatient (AMH1)
Residential Treatment for Youth (AMH2)
Adult Foster Care (AMH2)
Older/Disabled Adult (AMH2)
Special Projects

Community Crisis
Support Employment (AMH1)
Homeless (AMH1)
Residential Treatment (AMH2)
Non-Residential Adult (Designated)
A & D-Special Projects (AMH3)
A & D Residential Treatment - Adult (AMH4)
Continuum of Care (AMH5)
System of Care (CAF1)
Community Based Sexual Assault (CAF2)
Community Based Domestic Violence (CAF3)
Family Based Services (CAF5)
Foster Care Prevention (CAF6)
Enhanced Supervision (CAF8)
Nursing Assessments (CAF11)
Other Medical (CAF13)
IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)
Personal Care (CAF17)
Oregon Project Independence
SE #150 Family Support (SPD3)
SE #151 Children Long-Term Support (SPD4)
Licensing Fee
General Microbiology
Virology
Chlamydia (PHD4)
Other Test Fees (PHD5)
State Support for Public Health (PHD6)
(Newborn screening OF is used for match for the MCH block grant) (PHD11)
Prescription Drug Monitoring Program (PHD7)
HIV Community Services (PHD8)
General Funds - HST (PHD9)
Sexually Transmitted Diseases
Mental Health Treatment
Drug and Alcohol
Formerly Medically Needy (Organ Transplant) Clients
Workforce Training To Promote Medicaid Provider Participation
Undergraduate and graduate health professions education
OMIP
State Hospitals (OSH and BMRC)
Gero-Neuro

Demonstration Approval Period: July 5, 2012 through June 30, 2017
Amended July 5, 2012

X. GENERAL REPORTING REQUIREMENTS

Effective January 1, 2014, reporting requirements will change to reflect the new eligibility and benefits structure. The State will submit timely requests for amendment of the Demonstration, consistent with the Transition Plan required by Demonstration paragraph 13, in order to implement the reporting requirement changes by January 1, 2014.

59. **General Financial Requirements.** The State shall comply with all general financial requirements under Title XIX and XXI set forth in these STCs.
60. **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.
61. **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.
62. **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, CCO/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, CCO/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.
63. **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 68 and 71; and
- 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.

64. **Monitoring To Assure Progress in Meeting Demonstration Goals:** The State will submit to CMS a quarterly monitoring report to enable CMS to monitor the State's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of Demonstration goals.

- a. **Interim Reporting Format.** The State and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:

- i. Reducing Per Capita Expenditure Trend Growth: Section VIII;
 - ii. Quality Improvement Metrics: Section VII;
 - iii. Access to Care measures: Section VII;
- b. **Timeframe for Reporting.** The State will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.
- c. **Data Sources:**
 - i. Goal 1:
 - 1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with State);
 - 2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;
 - 3. Total Medicaid service spending per beneficiary; and
 - 4. CCO provider spending per beneficiary.
 - ii. Goal 2:
 - 1. Benchmarked metrics tied to incentive payments, including patient experience surveys;
 - 2. Data from the all payer-all claims database;
 - 3. Process Improvement Projects (PIPs);
 - a. EQRO studies;
 - b. Complaints and grievances;
 - c. Health risk assessment data;
 - d. Public health data;
 - e. Health risk assessment data;
 - f. Meaningful use attestation data;
 - g. State CCO monitoring reports; and
 - h. Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the Duals Demonstration.
- d. **Final Annual Report:** The State shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The State will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.
- e. **Penalty for Late Reporting:**
 - i. If the State fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the Demonstration, by issuing a reduction to the grant award in the amount

specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The State may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the State from reporting timely, the State can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	Days late
.2	15-30
.4	30-40
.8	41-50
1	51+

65. **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:
 - 1. FHIAP’s (Populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to

2. OHA direct coverage (Populations 1 through 11 in Attachment D) 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 in Attachment D are based on maximum plan out of pocket costs (excluding premium share) to:
 1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.⁴
 - iii. OPHP will monitor program expenditures for HK ESI (Population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) 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 in Attachment D) 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.

66. 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 CCOs/MCOs and benefit plans. The State will also monitor and report on disenrollment requests and the reasons for the requests.

67. 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 XIV of these STCs.

68. Enrollment Reporting.

- a. Through the end of the second quarter of FY 2014, each quarter the State will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of

⁴ 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.

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/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

XI. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

- 69. **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 XIII of these Terms and Conditions.
- 70. **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, through DY 9. DY 10 is defined as beginning November 1, 2011 and ending June 30, 2012. Beginning with DY 11, the Year is defined as beginning July 1, 2012 and ending June 30, 2013. DY 12 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 Waiver 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.
 - iv. DSHP Expenditures
 - v. CCO 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 paragraph 70.a.ii) above. However, certain Title XIX expenditures, as identified in paragraph 18.e.viii), 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 Demonstration to ensure that 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. The State completed this corrective action on November 30, 2009.

71. **Reporting Member Months:** The following describes the reporting of member months for 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 63 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 I - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1, 2,	
PLM Children	3, 4	
BCC Population	21	
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, 0(a), and 22.b).

72. **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.

73. **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.

74. **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 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.

XII. 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.

75. 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.
76. 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.
 77. 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.
 78. 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.
 79. 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.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

80. **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 70.
81. **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 71(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, CCO implementation 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 71(a)). Effective with the implementation of the ACA, these Expansion populations will become mandatory, and Oregon will no longer be at full risk for either enrollment or per capita cost.

82. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in paragraph 80. This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP 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.

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	\$504.08
PLM-A Pregnant Women	\$1,605.08	6.1%	\$1,702.99	\$1,806.87	\$1,917.16
PLM Children	\$613.21	6.2%	\$651.23	\$691.61	\$ 734.70
Individuals receiving treatment under the Breast and Cervical Cancer Medical (BCCTP) program		6.2%	\$		\$2504.78

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	\$391.86
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	\$658.53
Blind/Disabled	\$1,750.67	5.8%	\$1,852.21	\$1,959.64	\$2179.61
Foster Children	\$735.95	6.2%	\$781.58	\$830.04	\$887.03

The following table gives the projected PMPM costs for demonstration years 12 through 15. For DY 12 (July 1, 2013 to June 30, 2014) a blended per member per month was created to account for 4 months of State historical rate and 8 months of 2013 President's budget trend rate.

- a. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM 7/1/14-6/30/15	DY 14 PMPM 7/1/15-6/30/16	DY 15 PMPM 7/1/16-6/30/17
AFDC	\$529.80	4.5%	\$553.83	\$578.95	\$605.22
PLM-A Pregnant Women	\$2018.86	4.9%	\$2117.88	\$2221.76	\$2330.74
PLM Children	\$768.80	3.8%	\$798.32	\$828.98	\$860.81
BCCTP	\$2631.69	4.5%	\$2750.12	\$2873.87	\$3003.20

i. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Expansion Parents to 100% FPL	\$658.53	4.9%			
FHIAP (Medicaid)	\$352.72	4.9%			

ii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Old Age Assistance	\$721.39	4.1%	\$786.23	\$855.19	\$928.47
Blind/Disabled	\$2419.85	5.1%	\$2673.57	\$2946.88	\$3241.11
Foster Children	\$934.56	3.8%	\$977.06	\$1021.43	\$1067.77

Beginning 1/1/2014 MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
New mandatory adults	\$522.00	7%	\$559.88	\$600.50	\$644.07

83. 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. 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.

84. Composite Federal Share Ratio. The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the composite federal share. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process through an alternative mutually agreed to method.

85. 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 Demonstration expenditures are compared to the Federal Share of the cumulative OHP 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 70 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 OHP.
- b. Should the Demonstration be terminated prior to the end of the approval period (see paragraphs 9, 10, and 12, 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
DY 9	Cumulative budget neutrality cap plus:	0.25 percent
DY 10	Cumulative budget neutrality cap plus:	0.25 percent
DY 11	Cumulative budget neutrality cap plus:	0 percent
DY 12	Cumulative budget neutrality cap plus:	0.25 percent
DY 13	Cumulative budget neutrality cap plus:	0.25 percent
DY 14	Cumulative budget neutrality cap plus:	0.25 percent
DY 15	Cumulative budget neutrality cap plus:	0 percent

XIV. EVALUATION OF THE DEMONSTRATION

86. **Evaluation Design.** In the 120 days following the date of approval of this Demonstration, the State shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the State will consider the Evaluation Guidance in Attachment B. The evaluation will include:

- a. A discussion of the Demonstration hypotheses that will be tested, focusing on key areas of the State’s health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional Demonstration outcome measures;
- b. An analytical plan for assessing Oregon’s success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.
- c. Any other information pertinent to the State’s evaluative or formative research via the Demonstration operations.
- d. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;
- e. The draft plan shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation; and
- f. Any other information pertinent to the State’s evaluative or formative research via the Demonstration operations

87. **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.

88. **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.
89. **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 Organizations
 3. Coordinated Care Organizations
- D. Quality of care - Identify any quality assurance/monitoring activity in current quarter.

1. Fee-for-service
2. Managed Care Organizations
3. Coordinated Care Organizations

E. Access

1. Fee-for-service
2. Managed Care Organizations
3. Coordinated Care Organizations

F. Managed care, Coordinated Care Organizations

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	
<i>Pharmacy Only</i>	
<i>Family Planning Only</i>	
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.

ATTACHMENT C

Glossary of Terms Related to title XIX and XXI funded Children

Effective with the implementation of the ACA, changes to the Demonstration will require revision of the Glossary.

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 up to and including 200 percent of FPL, and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL);
 3. A private insurance component, Healthy KidsConnect, which is 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 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.

As of January 1, 2014: 1) Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP or Healthy Kids ESI components of this demonstration rather than enroll in the Medicaid or CHIP State plan, and 2) Parents and childless adults enrolled in FHIAP with income from 0 up to 133 percent of the FPL,

will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP State plans. Individuals currently receiving premium assistance who, based on an initial screening evaluation, do not appear to be eligible under the approved Medicaid or CHIP State plans will be afforded a full eligibility determination prior to termination. Individuals denied continued benefits will be offered the opportunity to have their information electronically transmitted to the State Affordable Insurance Exchange (Exchange) to be treated as an application for coverage and benefits through the Exchange.

- **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 FHIAP or Healthy Kids ESI. Children determined eligible by DHS or OHA are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP pays premium subsidies ranging from 50 to 95 percent for adults. Both FHIAP and Healthy Kids ESI pay 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, Healthy Kids ESI, or CHIP direct coverage (OHP Plus), and children who choose FHIAP or Healthy Kids ESI can move back to State plan direct coverage at any time.
- **Healthy Kids ESI/Child Only Premium Assistance and Healthy KidsConnect 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 up to and including 250 percent of FPL will receive State subsidies equaling about 90 percent of the child's monthly premium.
 - Families with incomes above 250 up to and including 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.
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- **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 FHIAP-eligible families with income from 0 up to and including 200 percent of the FPL are subject to the reservation list.

As of January 1, 2014 the FHIAP reservation list will no longer be applicable. Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP component of this demonstration rather than enroll in the Medicaid or CHIP State plan, and parents and childless adults enrolled in FHIAP with income below 133 percent of the FPL will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP State plans.

- **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.

Attachment D - Summary Chart of Populations Affected by or Eligible Under the Demonstration through December 31, 2013

ACA Implementation. As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII) of the Act and the collapsing of certain eligibility groups will revert to the Medicaid State plan.

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

21	Uninsured or underinsured women under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program (BCCTP)	Title XIX	Title XIX	0% up to 250% FPL	None	Limited – case-by-case basis	Base 1
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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	From 133% up to 185% FPL	None	OHP Plus	Base 1
13	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	From 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	0% up to 100% FPL	\$2,000	OHP Standard	Expansion

11	Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	0% up to 100% FPL	\$2,000	OHP Standard	Expansion
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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	From 0 % 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	From 0% up to 185% FPL	None	FHIAP	Expansion
16	<p>Until January 1, 2014:</p> <p>Uninsured targeted low income children ages 0 through 5, and</p> <p>Uninsured targeted low income children ages 6 through 18</p> <p>These children choose voluntary enrollment in FHIAP.</p>	Title XXI	Section 1115 and Title XXI	<p>From 133% up to and including 200% FPL</p> <p>From 100% up to and including 200% FPL</p>	None	FHIAP, including dental, well-baby, well-child, immunizations and emergency 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	From 0% up to and including 200% FPL	None	FHIAP	Expansion
18	Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	From 0% up to and including 200% FPL	None	FHIAP	Expansion

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
20	Until January 1, 2014, Uninsured children ages 0 through 18 with incomes above 200 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 premium assistance under 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, immunizations, dental and emergency services	Optional
22	Uninsured targeted low income children ages 0 through 5, and eligible for direct services under the CHIP State Plan Uninsured targeted low income children ages 6 through 18	Title XXI	Section 1115 and Title XXI CHIP State Plan	From 133% up to and including 200% FPL From 100% up to and including 200% FPL	None	OHP direct services;	Optional

	<p>and eligible for direct services under the CHIP State Plan</p> <p>Targeted low income children ages 0 through 18 who are eligible under the CHIP state plan (under Healthy KidsConnect).</p> <p>Uninsured target low income children ages conception to birth who reside in specific participating counties and are eligible for the unborn option.</p>			<p>Above 200% up to and including 300% FPL</p> <p>From 0% to 185% of the FPL</p>		<p>Healthy KidsConnect private product under contract with OHA;</p> <p>OHP direct services as limited for unborn population **</p>	
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* 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.

**** Unborn population is precluded from receiving the following services: abortion, death with dignity, sterilization, hospice services and postpartum services beyond the global rate

Attachment E: Menu Set of Quality Improvement in Focus Areas

The measures in bold would be the core measures for each focus area and would be required of any CCO selecting that focus area.⁵ The purpose for these focus areas is to reduce costly, inappropriate, and unnecessary care where possible without decreasing the quality of care. The State may wish to add to this menu to account for how they will measure access and quality for individuals receiving care FFS—this should include populations receiving costly long term care and supportive services.

<u>Goal</u>	<u>Example Measures</u> <u>(bolded measures are core</u> <u>for that focus area)</u>	<u>Example</u> <u>Interventions</u>
1) Reducing rehospitalizations	Hospital readmissions (across age groups); Plan all-cause readmissions; hospital cost per patient and total cost of care per patient over specific time periods for patients enrolled in care transition programs; care plan for members with long-term care benefits; follow-up after hospitalization for mental illness; medication reconciliation post-discharge; timely transmission of transition record	Financial penalties for high rates of rehospitalizations and/or incentives for low rates (must remove the financial incentive to rehospitalize through incentives and penalties), care transition programs. Also see “super-utilizers” interventions
2) Addressing discrete health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers	These will vary depending on issue identified, but could include disease specific measures such as Diabetes Care measure, pediatric asthma hospitalization	Ideally these would include a wide range of activities by multiple entities such as pediatric community based asthma initiatives, enhanced by coordinated public health interventions to target tobacco cessation. Clinical diabetes care initiatives can dovetail with public health interventions such as outreach programs and community based obesity reduction programs

⁵ The rest of the measurement strategy will be determined later but sample additional measures are included for discussion purposes.

<u>Goal</u>	<u>Example Measures (bolded measures are core for that focus area)</u>	<u>Example Interventions</u>
Reducing utilization by –super-utilizers”	Cost of care measures (total cost of care per patient over specific time period), and the readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; and outpatient and ED utilization	Community-based outreach programs to better address the needs of high utilizers. Successful programs have consisted of community-based outreach programs (including in person programs beyond telephonic case management), nurse care coordination, home visits, same day appointments, and data sources adequate to target the superutilizers. Oregon’s proposal includes pieces of these, including community health workers to help beneficiaries navigate the system and access resources; coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; CCO efforts to integrate information flow across providers. It is critical these services are appropriately targeted
Integrating primary care and behavioral health	Screening for clinical depression & follow-up plan; screening and referral for alcohol or drug misuse ; initiation and engagement with alcohol and drug treatment; follow-up after hospitalization for mental illness ; mental health assessment for children in DHS custody,	Global budget and single point of accountability for behavioral and physical health; co-location of mental health and primary care which includes collaborations between the mental health and primary care providers to develop and execute a shared treatment plan, including

<u>Goal</u>	<u>Example Measures</u> (bolded measures are core for that focus area)	<u>Example Interventions</u>
	mean cost for outpatient mental health and medications per patient; mean cost for inpatient mental health and substance abuse care per patient	coaching and counseling, improved systems for records sharing
Ensuring appropriate care is delivered in appropriate settings	Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization, Hospital readmissions (across age groups); Plan all-cause readmissions, primary care access measures	Narcotics registries, programs to address “super-utilizers”, targeted case management for frequent ED users, connect vulnerable patients with appropriate behavioral health and social services
Improving perinatal and maternity care	Early elective delivery before 39 weeks , preterm deliveries, perinatal measures such as screening for tobacco use, tobacco cessation counseling, breastfeeding at discharge	Collaboration with Strong Start program on early elective delivery, interconception care, home visiting programs for first time mothers
Improving primary care for all populations	Proportion of individuals with a patient-centered primary care home (PCPCH) and proportion of certified PCPCHs in a CCO’s network, and level of certification; rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization ; ratio of primary care spending to specialty & hospital spending over time, well-child visits, tobacco	CCO strategies to encourage their providers to attain highest levels of PCPCH recognition; development of community health workers to help increase access to culturally and linguistically appropriate primary care; CCO requirements for health assessments and person-centered care plans, certified EHR adoption and meaningful use; PCMH participation incentives; shared incentives across primary, specialty, long-

<u>Goal</u>	<u>Example Measures</u> (bolded measures are core for that focus area)	<u>Example Interventions</u>
	use screening and cessation counseling for patients >12 years old, BMI recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active medication list (including allergies)	term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to an NP or doctor); PHRs; open-access scheduling and sick hours.

Attachment F: CCO Services Inventory

	Program Area	Program/Service/Function	Proposed Timeline for Inclusion in Global Budgets				Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	2% pmpm growth test	Program wide monitoring only
1	Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	X				Yes	Yes
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X				Yes	Yes
3	Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	X				Yes	Yes
4	Mental Health	Children's Statewide Wraparound Projects	X				Yes	Yes
5	Mental Health	Exceptional Needs Care Coordinators	X				Yes	Yes
6	Mental Health	Non-forensic intensive treatment services for children(Inpatient Psychiatric Facility Services for Individuals Under age 21)	X				Yes	Yes
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X				Yes	Yes

8	Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	X				Yes	Yes
9	Mental Health	Supported Employment and Assertive Community Treatment		X			Yes	Yes
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Optional in counties where currently operating	X			Yes	Yes
11	Addictions	Youth residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013			Yes	Yes
12	Addictions	Adult residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013			Yes	Yes
13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Optional in counties where currently operating	X			Yes	Yes
14	Targeted Case Management	HIV/AIDS Targeted Case Management		X			Yes	Yes
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon		X			Yes	Yes
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)		X			Yes	Yes

17	Transportation	Non-Emergent Medical Transportation		X			Yes	Yes
18	Mental Health	Adult Residential Mental Health Services		X July 1, 2013			Yes	Yes
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)		Optional	X		Yes	Yes
20	Dental	OHP dental coverage	Optional	Optional	Optional Until July 1, 2014		Yes	Yes
21	Mental Health	Young Adults in Transition Mental Health Residential			X		Yes	Yes
22	Mental Health	Personal Care 20 Client Employed Provider			X		Yes	Yes
23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)				X	No	Yes
24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)				X	No	Yes
25	Long Term Care	Long term care institutional and community supports				X	No	Yes
26	Mental Health	State Hospital Care - Forensic				X	No	Yes

27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations				X	No	Yes
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)				X	No	Yes
29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB				X	No	Yes
30	Mental Health	OHP-covered mental health drugs				X	No	Yes
31	Other	Hospital Leverages: GME, Pro-Share, and UMG				X	No	Yes
32	Other	FQHC Full-Cost Settlements				X	No	Yes
33	Other	A & B Hospital Facilities Settlements				X	No	Yes
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)				X	No	Yes

35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)				X	No	Yes
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)				X	No	Yes
37	Targeted Case Management	Tribal Targeted Case Management				X	No	Yes
38	Other	DSH				X	No	Yes

Note: All services are state plan services with the overlay of the Section 1915(b) waiver for transportation and the Section 1115 demonstration that includes application of the Prioritized List of Health Services.

Attachment H: Calculating the Impact of Health Systems Transformation