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State/Territory Name: Oregon

State Plan Amendment (SPA) #: OR-24-0141 and OR-24-0140

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

December 5, 2025

Dr. Emma Sandoe, PhD
Medicaid Director
Oregon Health Authority
500 Summer Street Northeast, E-65
Salem, OR 97301-1079

Dear Director Sandoe:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendments (SPAs) OR-24-0141 and OR-24-0140, submitted on May 16, 2024, have been approved. The effective date for these SPAs is January 1, 2024.

These SPAs, and the corresponding Medicaid SPA (OR-24-0006), allow Oregon to transition the majority of its separate CHIP to a Medicaid expansion program effective January 1, 2024. The only individuals remaining in the separate CHIP are those covered under the from-conception-to-end-of-pregnancy (FCEP) option.

Specifically, SPA OR-24-0141 removes references throughout the CHIP state plan to targeted low-income children who were previously covered in the separate CHIP and are transitioning to Medicaid. SPA OR-24-0140 updates the income standards for the state's title XXI Medicaid expansion population.

Your Project Officer is Jennifer McIlvaine. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at jennifer.mcilvaine@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Jessica Stephens/

Jessica Stephens
Acting Deputy Director

CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Oregon

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))
Designee-Medicaid Director
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Sejal Hathi, MD, MBA. **Position/Title: Director, OHA**
Name: Vivian Levy **Position/Title: Interim Director, Medicaid/CHIP**
Name: **Position/Title:**

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is** 0938-1148 (CMS-10398 #34)**. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the**

accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete

response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.
The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)

6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility

and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)

- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))
Medicaid Expansion Group:
Children ages 0 to 19 with family income up to 300% of the Federal Poverty Level.
Separate CHIP:
From conception to end of pregnancy(FCEP), with family income up to 185% of the Federal Poverty Level and not eligible for Medicaid.

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 ☒ Check to provide an assurance that expenditures for child health assistance will not be

claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: **July 1, 1998**
Implementation Date: **July 1, 1998**

State Plan Amendment #2: Minor revisions to performance measures in approved XXI State Plan
Submitted: May 30, 2000
CMS Approved: September 11, 2000

State Plan Amendment #3: Increase enrollment cap to 19,800
Submitted: December 12, 2000
CMS Approved: March 9, 2001

State Plan Amendment #4 Compliance with final CHIP regulations and updated program descriptions
Submitted: July 31, 2002
CMS Approved: April 15, 2003

State Plan Amendment #5: Asset limit increase to $10,000
Submitted: August 19, 2004
CMS Approved: November 10, 2004
Effective date: October 1, 2004

State Plan Amendment #6: Duration of eligibility period increased to 12 months
Submitted: May 16, 2006
CMS Approved: August 1, 2006
Effective Date: June 1, 2006

State Plan Amendment # 7: Unborn child expansion
Submitted: July 31, 2007
Approved: April 9, 2008
Effective: April 1, 2008

State Plan Amendment #8: Require SSN on application
Submitted: September 13, 2007
Approved: December 12, 2007
Effective: October 1, 2007

State Plan Amendment # 9: Transition the following targeted low income children from Section 1115 demonstration to the state plan: children ages 0 through 18 above 170 percent of the FPL up to 185 percent of the FPL.
Submitted: November 30, 2007
Approved: September 16, 2008
Effective: November 1, 2007

State Plan Amendment # 10: This amendment expands the income eligibility level for CHIP children through age 18 from 185 percent of the Federal poverty level (FPL) up to and including 300 percent of the FPL under the State's Healthy Kids initiative. This SPA is a companion amendment to the State's section 1115 title XXI demonstration amendment. This SPA also creates a new private insurance option, referred to as Healthy KidsConnect, specifically for children from 200 up to and including 300 percent of the FPL under Secretary-approved coverage under the CHIP state plan. In addition, this SPA institutes an Application Assistance Program to assist families applying for CHIP and other child health programs in the State as part of its Healthy Kids initiative, finances an outreach and enrollment grant program designed to provide culturally-specific and targeted outreach and direct application assistance to families in racial, ethnic and language minority communities living in geographic isolation or with additional access barriers,

reduces the waiting period of uninsurance for CHIP coverage from 6 months to 2 months, and eliminates the asset test in CHIP This amendment will have a retroactive effective date of October 1, 2009, for the expansion of eligibility from 185 percent of FPL up to and including 200 percent of the FPL, as well as for the application assistance program, outreach and enrollment grant program, the waiting period reduction, and elimination of the asset test.
Submitted: July 27, 2009
Effective: October 1, 2009
This amendment will also have an effective date of January 1, 2010, for the expansion of eligibility above 200 percent of the FPL up to and including 300 percent of the FPL. However, the State must receive approval for its section 1115 demonstration amendment in order to permit children to enroll in its premium assistance programs.
Submitted: July 27, 2009
Approved: December 18, 2009
Effective: January 1, 2010.

State Plan Amendment #11: Expand Unborn population coverage to Benton, Clackamas, Hood River, Jackson and Lincoln counties.
Submitted: August 26, 2009
Effective: October 1, 2009
This amendment also closes the expansion in Lincoln County effective December 31, 2009.
Submitted: December 22, 2009
Approved: September 20, 2010
Effective: January 1, 2009

State Plan Amendment # 12: CHIPRA provisions related to those who have not met the 5 year waiting period for immigrant children.
Submitted: July 27, 2009
Approved: May 18, 2010
Effective: October 1, 2009

State Plan Amendment # 13: Designate express lane eligibility agencies as the Supplemental Nutritional Assistance Program (SNAP) and selected Department of Education, National School Lunch Program (NSLP).
Submitted: August 9, 2010
Approved: October 21, 2010
Effective: August 1, 2010

State Plan Amendment #14: Expand Unborn population coverage to Lane county.
Submitted: October 11, 2010
Effective: January 1, 2011
This Amendment also revises the budget month used for income eligibility
Approved: December 30, 2010
Effective: November 1, 2010
State Plan Amendment #15: withdrawn

State Plan Amendment #16: Expand Unborn population coverage to Columbia, Crook, Douglas, Josephine, Jefferson, Morrow, Union and Wasco county.
Submitted: March 28, 2011
Effective: July 1, 2011
Approved: May 26, 2011

State Plan Amendment #17: (a) Expand Unborn population coverage to Umatilla county. (b) Provisions implementing temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or FEMA declared disaster areas. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas. (c) This amendment also closes the expansion in Josephine county effective July 1, 2011.
Submitted: March 29, 2012
Effective: April 1, 2012
Approved: April 30, 2012

State Plan Amendment # 18: This amendment is to provide federal funding for the Oregon Poison Center (OPC) under a health services initiative.
Submitted: May 4, 2012
Effective: April 1, 2012
Approved: September 27, 2012

State Plan Amendment # 19: Children currently enrolled in Healthy KidsConnect with incomes between 200 and 300% FPL will be converted to CHIP direct coverage. Expand OHP Plus direct coverage to children to at or below 300% and reduce the period of uninsurance from 2 months to zero.
Submitted: 8/29/13
Effective: 8/23/13
This Amendment also expands the unborn population coverage statewide.
Submitted: 8/29/13
Effective: 10/1/13
Approved: 11/22/13
State Plan Amendment # 120 (13-0120) ACA MAGI elig. Form CS15
Adds new subsection 4.3.4, CS13 adds new subsection 4.3.5. CS7, CS8 supersede section 4.1.1, 4.1.2 and 4.1.3.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/10/14

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OR-13-0120 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
		CS9	Conception to birth	Incorporate under new section 4.3.5
		CS13	Deemed newborn	Incorporate under section 4.3

State Plan Amendment # 121 (13-0121) ACA elig process. Form CS24 supersedes section 4.3 & 4.4.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 5/5/14

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OR-13-0121 Effective Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4

State Plan Amendment # 122 (13-0122) ACA established 2101(f). Form CS14 adds new subsection 4.1. 10.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/3/14

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OR-13-0122 Effective Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1

State Plan Amendment #123 (13-0123) ACA Non financial elig. Form CS17 superseded section 4.1.5. CS18 superseded section 4.1.0, 4.1-LR; 4.1.1-LR. CS19

supersedes section 4.1.9. CS21 supersedes section 8.7. CS27 supersedes section 4.1.8 and CS28 supersedes section 4.4.3.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/10/14

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OR-13-0123 Effective Date: January 1, 2014	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8

State Plan Amendment # 124 (13-0124) ACA Chip to XXI Medicaid. Form CS3 supersedes section 4.0.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/3/14

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
OR-13-0124 Effective Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0

State Plan Amendment # 127 (13-0124) FFM assessment designation. Form CS24
Submitted: 9/17/15

Effective: 11/1/15
Approved: 12/2/15

State Plan Amendment # 128 (18-0128) Mental Health Parity
Submitted: 6/29/18
Effective: 10/2/18
Approved:9/12/19

State Plan Amendment # 129 (18-0129) Hospital Presumptive Eligibility. Form CS28
Submitted: 7/18/18
Effective: 2/1/18
Approved:8/23/18

State Plan Amendment # 130 (OR-19-0130) CHIP MCO provisions
Submitted: 6/13/19
Effective: 7/1/18
Approved: 7/11/19

State Plan Amendment # 19-131 (OR-19-0131) Remove ELE
Submitted: 10/24/19
Effective: 7/1/19
Approved: 10/31/19

State Plan Amendment # 20-131 (OR-20-0131) CHIP COVID-19 provisions: Oregon is requesting to provide temporary adjustments to policies related to tribal consultation, changes in circumstances, and presumptive eligibility during the Federal COVID-19 public health emergency.
Submitted: 4/30/20
Effective: 3/1/20
Approved: 6/30/20

State Plan Amendment OR-20-0132 CHIP Behavioral Health Coverage : Required preprint for BH benefit added as a mandatory benefit under the SUPPORT Act. Oregon had already included BH benefits since 1998.
Submitted: 6/18/20
Effective: 10/24/19
Approved: 3/16/21
State Plan Amendment OR-21-0133 CHIP HSI: This amendment is to add the Oregon Parenting Education Collaborative as a Health Services Initiative.

Submitted: 11/16/21
Effective: 12/1/21
Approved: 10/18/22

State Plan Amendment OR-22-0134 CHIP COVID-19 provisions: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.
Submitted: 1/26/22
Effective: 3/11/21
Approved: 3/1/22

State Plan Amendment OR-22-0135 12-Month Postpartum Continuous Eligibility in CHIP.
Submitted: 4/1/22
Effective: 4/1/22
Approved: 5/25/22

State Plan Amendment OR-23-0136 CHIP HSI: expand HSI to cover up to 12 months postpartum, to the extent of available administrative funds, for mothers in the unborn/conception to end of pregnancy group.
Submitted: 3/29/23
Effective: 7/1/23
Approved: 6/8/23

State Plan Amendment OR-23-0137 Align performance goals with CHIP annual report.
Submitted: 6/30/23
Effective: 7/1/23
Approved: 9/5/23

State Plan Amendment OR-23-0138 Assuring coverage of age-appropriate vaccines and their administration, without cost sharing.
Submitted: 12/8/23
Effective: 10/1/23
Approved: 1/10/24

State Plan Amendment OR-24-0139-Withdrawn

State Plan Amendment 24-00140- Form CS3 and CS27 in MMDL

State Plan Amendment OR-24-0141
Purpose of SPA: Transition from separate CHIP to Medicaid expansion CHIP. The from conception to end of pregnancy (FCEP) population will remain a separate CHIP.
Submitted: 2/21/24
Effective: 1/1/24
Approved:

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
24-0140	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program Updates ages and income levels of children that will be eligible for Medicaid expansion	13-0124
	CHIP-Non-Financial Eligibility	CS27	General Eligibility - Continuous Eligibility	22-0135
The following MMDL forms will become obsolete:				
24-0140	Non-Financial Eligibility	CS19	Social Security Number	13-0123
24-0140	MAGI Eligibility & Methods	CS7	Targeted Low-Income Children	13-0120

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Oregon tribal entities were consulted in the submission of this SPA utilizing the Dear

Tribal Leader Letter (DTLL) process. The DTLL was distributed to the Tribes on April 24, 2021. There was no request for additional face-to-face consultation, nor any comments related to this SPA.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Historical:

Prior to implementation of CHIP in 1998, approximately 870,000 children in the state of Oregon were under the age of 19. About 92 percent of them, 800,000, had health insurance coverage of some form. Children of Hispanic or racial minority origin are more likely than their Caucasian counterparts to be uninsured. Fourteen percent of Hispanic children and 9 percent of other minority children are uninsured, compared with only 7 percent of Caucasian children. Most uninsured children live in households earning less than $25,000 per year, while median household income for all children in the state is more than $40,000 per year.

The economic conditions of the state and nation reflect an increase in the number of uninsured. The 2006 Oregon Population Survey (OPS) shows 12.6% of children under age

19 lacked health insurance coverage last year compared to 13% in 2004 and 10.6% in 2002.

The primary source of health coverage for most children is an employer-based policy, most often sponsored by a parent's employer. In 1998 Employer-based coverage accounted for 82 percent of all children's health insurance coverage in the state, while public sources made up 13 percent and the remaining 5 percent was from other sources. In 2007 Employer-based coverage decreased as the unemployment rate increased.

During Oregon's 2009 Legislative Session, HB 2116 created the Healthy Kids initiative. Healthy Kids provides coverage for uninsured children through age 18 in the State. The objective of Healthy Kids is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. HB 2116 increases the FPL from 185 percent of FPL up to and including 300 percent of FPL for children.

According to the Kaiser Family Foundation, the breakdown of health insurance coverage fo children 0-18 in 2022 in Oregon was:

- **51.4% of children have employer sponsored health coverage**
- **4.7% of children have individually purchased health coverage**
- **39.9% of children have Medicaid coverage (CHIP is included)**
- **3.3% of children are uninsured**
- **0.7% of children have other public coverage.**

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.1005.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at **42 CFR 457.10**. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Oregon Poison Control Center program:

Oregon will use CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the Oregon Poison Center (OPC). The OPC provides emergency telephone treatment advice, referral assistance, and information to manage exposures to poisonous and hazardous substances. The OPC answers poisoning emergency calls from the general public as well as health care providers needing assistance 24 hours a day, 365 days each year at no charge. At all times, Specialists in Poison Information,

Certified Specialists in Poison Information, and toxicologists are available to manage cases. The service is provided via a toll-free telephone number to all communities throughout Oregon, including under-served, low income, and indigent populations. Services are available by use of an interpreter in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TTY).

The OPC provides public education programs directed towards pediatric accidental poisoning as well as targeted "at-risk" populations. Educational materials and teaching curricula are distributed throughout the state, free of charge. Materials are also available in Spanish, Vietnamese and Russian. The OPC participates in a variety of community injury prevention including health fairs.

The OPC receives approximately 46,000 calls from Oregonians annually involving individuals exposed to poisons or hazardous substances. Sixty-four percent of all poisoning exposure calls received involve children under age 19. For CHIP eligible children, over 38 percent of the total calls relate to poisoning exposures of children in families whose annual household incomes is $44,700 or less (200% FPL for a family of 4 in 2011). In addition to calls regarding exposures, the OPC receives over 7,800 calls each year from Oregonians requesting information about poison prevention, effective use of chemicals, drug identification, substance abuse and other medical questions. These calls are considered preventive.
OPC intervention resulted in over 92 percent of the exposure calls (in children under age 19) being handled in the home so the children did not have to use an emergency department or need a 911 call and response.

The Authority has no special funding arrangement with the providers for these services and they retain 100% of the approved reimbursement from the state. Providers do not return any portion of the payments to the state.

Oregon Parenting Education Collaborative:

Background:
As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Oregon is doing a health services initiative that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to support the Oregon Parenting Education Collaborative (OPEC). The aim of this initiative is to improve children's social and emotional development by expanding the availability of parenting education and parenting support programs within the state. Parenting education has been shown to be effective in improving the emotional and behavioral adjustment of children and helping them to thrive, as well as enhancing the

psychosocial well-being of parents. Currently, parenting education programs in Oregon are only providing access to a fraction of the families with children in Oregon.

OPEC is a statewide system of parenting education "Hubs," in support of the vision that all Oregon parents will have access to high-quality parenting education programs that support them in their critical role as their children's first and most important teachers. OPEC Hubs coordinate parenting education efforts for their regions and provide parenting education services and supports through direct service and partnerships that are evidence-based and/or culturally responsive/-specific.

OPEC programs are for all families and strive to build community while honoring each family for their values, identities, home language, culture, and lived experiences. Currently, 41% of families receiving parenting education through OPEC are enrolled in Medicaid/CHIP and the majority (>60%) access one or more resources available to low-income families (e.g., Head Start). Hubs use a multipronged approach to reach families. This approach includes providing parenting education opportunities (e.g., multi-session class series, parenting workshops, family activities) that are open to all families in a given community or county as well as offering targeted parenting education opportunities that support families from specific backgrounds or with specific needs (e.g., culturally specific parenting education, programs for teen parents). OPEC is administered by Oregon State University (OSU) in partnership with four Oregon foundations (Oregon Community Foundation, The Ford Family Foundation, Meyer Memorial Trust, and The Collins Foundation).

Through the OPEC statewide infrastructure, OPEC Hubs receive ongoing strategic planning and technical assistance support, have access to professional development for parenting education professionals, and engage in a robust data collection effort. The strength of the OPEC infrastructure along with OPEC's capacity for robust data collection has positioned OPEC well to serve as a state partner in effectively and rapidly expanding access to parenting education resources and programs.

The COVID-19 pandemic has brought heightened awareness to the role families play in supporting children throughout their development. Alarmingly, the context of the pandemic has placed increasing demands and stresses on family life, exacerbating existing challenges in family-related policies and supports and inequities. Children and youth (and by extension their parents/caregivers) are experiencing mental health crises and in need of support. Parenting education has the potential to fill this need for support at a critical time, to rapidly expand access to prevention supports, and to normalize/destigmatize these resources beyond the pandemic context.

SERVICES:

OPEC Hubs offer a variety of family programs as part of their parenting education menu. Family programs include parenting class series, parenting workshops, parenting support activities, and family activities/events. Some Hubs additionally offer home visitation and one-on-one parent coaching provides parenting education to parents through a one-on-one approach in their own home, typically while their children are present. Home visitors often follow a set curriculum that can be adapted to the particular needs of the family. Programs are offered both virtually, through hybrid models, and in-person (using state-required safety protocols).

Supporting the delivery of evidence-based and culturally responsive parenting education programs requires attention to best practices that minimize barriers to family participation. As such, Hubs sometimes use funds for family meals (when classes are held during mealtimes) and snacks, transportation expenses (e.g., gas cards for families who would not otherwise be able to attend on account of limited transportation) and onsite childcare for classes conducted in person. Specifically:

Food: Food is supplied only to increase access to services and is primarily provided when classes are held during mealtimes. Snacks are occasionally provided during class time.

Transportation: Funds for transportation are only provided when it correlates to an expense incurred travelling to and from a parenting class. Given much of Oregon is rural, gas cards are occasionally supplied to families in need of transportation assistance. The amount of money in the gas card is based upon the mileage from home to class.

Childcare:
Some Hubs do provide onsite childcare for classes conducted in person. When childcare is provided it is only provided by licensed providers and in facilities that are licensed by the state.

ASSURANCES:

Oregon Health Authority (OHA) assures that the Parenting Education Programs health services initiative described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

The OHA has no special funding arrangement and assures the *parenting education* providers retain all (100 percent) of the funds transferred (state and federal) to them for the services rendered.

<u>Postpartum Care Extension:</u>

Effective July 1, 2023, the state will use up to 10 percent of federal CHIP administrative funds under the Health Services Initiatives for extending postpartum coverage to 12 months from the end of the pregnancy through the end of the month in which the 12th month falls, for the individuals covered under the from conception to end of pregnancy option (FCEP) (also known as the "unborn" option), whether received fee-for-service or through a managed care plan.

On March 11, 2021, President Joe Biden signed the American Rescue Plan Act of 2021 (ARPA) into law. This allows states to extend its postpartum coverage from 60 days to 12 months, effective April 1, 2022. This extension is to be provided to Medicaid and CHIP pregnancy groups.

Because the ARPA does not address the CHIP FCEP, Oregon is proposing this HSI to prevent disparity among the groups and provide the 12-month postpartum period to its unborn CHIP population.

All pregnant individuals should receive comprehensive care during the postpartum period to assess their physical recovery from pregnancy and childbirth, address chronic conditions (such as diabetes or hypertension), address mental health issues (including postpartum depression), discuss reproductive health (including contraception and birth spacing), and ensure continuity of care.

The benefit package available during the extended postpartum period will be identical to coverage for pregnant women under the Medicaid state plan.
This coverage will directly benefit children's health. Research shows that when mothers do not have access to care for mental health, substance use disorder, or other medical conditions, they have limited resources to fully respond to their child's health needs. Untreated postpartum depression or substance use disorder can lead to child abuse and neglect, disruption in parental attachment, and adversely impact the child's development. Children are less likely to access preventive care, attend well-child visits, complete immunization schedules, and more likely to experience avoidable hospitalizations when their parent does not have access to coverage.

There are approximately 25,200 individuals enrolled in Oregon's FCEP Option with

income from 0 up 185 percent of the FPL served annually. The state will report metrics about its extended postpartum HSI as part of its annual CARTS report.

The State assures that the HSI programs will not supplant or match CHIP federal funds with other federal funds or allow other federal funds to supplant or match CHIP federal funds.7

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)) ; (ARRA #2, CHIPRA #3,

issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

The Oregon Health Authority (OHA) has regular quarterly meetings with the nine federally recognized Tribes, Urban Indian Programs and Indian Health Service (IHS) representatives. The agenda's are mainly driven by the Indian communities of Oregon, Urban Indian Programs and Indian Health Service (IHS) representatives and are constructed by requesting topic's to be discussed at the meeting. These meetings are referred to in Oregon as Senate Bill 770 in reference to the legislation authoring the meeting. The OHA may engage the tribal and urban program representatives outside of the meeting setting through correspondence in the event a policy change is needed more quickly than the next 770 meeting will support. Each Tribe and Indian Organization selects its representative to the meetings based on whom the Tribe or Indian Organization feels is best to represent their needs.

The Division discusses proposed State Plan Amendments, waiver amendments, demonstration project proposals. Policies or rule-making that may have a direct impact on American Indians, Tribal entities and urban Indian programs or IHS in the SB 770 quarterly meetings.
Impacts that are considered to have direct effects on Native Americans, Urban Indian programs or IHS are changes that would impact eligibility determinations, changes that reduce payment rates or changes in payment methodologies, reductions in covered services, changes in provider qualifications/requirements, and proposals for demonstrations or waivers.

Process:
Thirty (30) days prior to a State Plan submission to the Centers for Medicare and Medicaid Services (CMS), the Division distributes documents describing a proposed State Plan Amendments (SPA). This is normally discussed in a scheduled quarterly SB 770 meeting. Approximately ten (10) days prior to the quarterly 770 meeting the Division distributes the agenda and documents describing a proposed SPA. This is distributed through the Tribal Liaison to the nine federally recognized Tribes, Tribal Urban Indian programs and Indian Health Service (IHS) representatives. The types of entities on the distribution list includes, but is not limited to:

a. **Oregon Tribal Governments (i.e. Tribal Executive Council, Tribal Business Council, etc.)**
b. **Tribal Chairman or Chief or their designated representative(s)**
c. **Tribal Health Clinic Executive Directors of Oregon's 638/FQHC providers**
d. **IHS representatives**
e. **Tribal Organizations established to represent IHS and Tribal health programs and such as the Northwest Portland Indian Health Board**
f. **Urban Indian program(s) Executive Director(s) or designee(s)**

In instances where a SPA would need to be submitted prior to a regularly scheduled '770' meeting the Division would utilize electronic mail or schedule conference calls.

The Division may also utilize an expedited process in the event a deadline is outside the control of the Division, or in severely time limited situations. The expedited process includes at a minimum, 10 days in advance of the change the Division provides written notification with the proposed change; anticipated impact; method for providing comments/questions; timeframe for feedback; and an opportunity for a face-to-face meeting or conference call if requested.

Tribal, Urban Indian program and IHS designees are invited to attend all Divisions' Rule Advisory Committee meetings to provide additional input on rule concepts and language.

Section 3. Methods of Delivery and Utilization Controls

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☐ Yes, the State uses a managed care delivery system for all CHIP populations.

☒ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the

State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Generally, Oregon uses a managed care delivery system, known as Coordinated Care Organizations, for the FCEP population. The FCEP population can, however, be enrolled in a CCO or remain FFS for their health care services, due to individual circumstances. Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b)) **Oregon's CHIP program coverage is called the OHP which is the same coverage under its Medicaid State Plan and 1115 Waiver demonstration. The program utilizes the Health Evidence Review Committee's prioritized list of health services as one of its main tools for utilization control. This prioritized list is authorized under Oregon's' 1115 demonstration waiver. Other methods are the use of Prior authorized services**

through medical necessity review.

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others. **Services that are carved out of MCE coverage and provided under the state's FFS program are Standard Therapeutic classification 7 and 11 prescription drugs; Long Term care Services and Supports and Targeted Case Management. Family Planning services are considered open access, meaning the person is enrolled in an MCE however, they can go to the provider of their choice even if the provider is not in the MCOs network. If the provider is out of network the claim is paid FFS.**

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☒ Capitation payment **PMPM by category**
  Describe population served: **from conception to end of pregnancy population**

☒ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☒ Capitation payment
- ☐ Other (please explain)

Describe population served: **from conception to end of pregnancy population**

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☒ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☒ Capitation payment **PMPM by category**
- ☐ Other (please explain)

  Describe population served: **from conception to end of pregnancy population**

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
☐ Oversight responsibilities for the activities of FFS providers in the FFS program
☐ Provision of payments to FFS providers on behalf of the State
☐ Provision of enrollee outreach and education activities
☐ Operation of a customer service call center

☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
☐ Coordination with behavioral health systems/providers
☐ Other (please describe)

3.1.2.2 ☒ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about

coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).

- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☒ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☒ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☒ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☒ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☒ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

☐ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
☒ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information. **The State only requires CCOs to meet the 85% MLR. DCOs and MHO are not required to meet the 85% MLR.**

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

☒ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☒ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the

disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☒ Yes
☐ No

If the State uses a default enrollment process, please make the following assurances:

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☒ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☒ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☒ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☒ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☒ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☒ Yes
☐ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☒ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☒ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☒ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times: **Oregon's 1115 waiver:21-W-00013/10 and 11-W-00160/10 permits us to utilize 30 day. STC #7 To enable managed care entities to permit enrollees eligible through Medicaid or the CHIP state plan, a period of only 30 days after enrollment to disenroll without cause, instead of 90 days, except beneficiaries newly entering a managed delivery system. All beneficiaries newly entering a managed delivery system receive 90 days to disenroll. Beneficiaries newly entering a managed delivery system are individuals who have never had Coordinated Care Organization -enrollable Oregon Health Plan eligibility. (Applies to all Medicaid state plan populations listed in Attachment D.)**

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42

CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☒ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☒ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☒ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;

- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☒ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
  - That oral interpretation is available for any language and written translation is available in prevalent languages;
  - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
  - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the

potential enrollee based on their specific circumstance;

- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;

- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and

- What tier each medication is on.

3.5.15 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 ☒ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20.

3.6.4 ☒ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☒ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☒ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☒ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☒ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the

MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☒ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☒ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☒ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☒ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☒ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☒ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☒ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- ☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- ☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- ☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- ☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- ☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must

either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☒ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☒ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☒ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☒ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 ☒ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☒ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☒ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☐ Yes
☒ No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 ☐ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☒ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☒ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☒ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☒ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☒ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to

and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 ☒ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☒ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☒ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☒ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☒ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☒ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☐ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;

- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

3.9.24 ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☒ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☒ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☒ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☒ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☒ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

☒ Encounter data in the form and manner described in 42 CFR 438.818.

☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.

☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.

☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.

☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.

☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☒ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☒ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The result of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☒ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☒ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☒ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 ☒ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☒ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☒ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

3.12.1.1 ☒ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;

- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a “significant change” for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☒ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into

consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☒ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☒ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☒ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☒ The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☒ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

3.12.2.1.1 ☒ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

3.12.2.1.2 ☒ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 ☒ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☒ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 ☒ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☒ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this

information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

☒ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

☒ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☒ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☒ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☒ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 ☒ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

3.12.5.3.1 ☒ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☒ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☒ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;

- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about

all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and

- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☒ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☒ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the

benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Oregon Administrative rules for quality assurance and quality improvement review process require OHA contracted coordinated care organizations to have an internal utilization review infrastructure and to specifically monitor utilization of preventive care, the operation and outcome of referral procedures, and persistent or significant OHA member complaints. OHA staff annually reviews health plan compliance with utilization and quality assurance requirements to ensure appropriate utilization of health care services. The quality improvement process ensures services provided are appropriate and medically necessary, and approved by the state. The following are examples of administrative mechanisms required of the managed care plans in the Oregon Health Plan Medicaid Demonstration Project, which are also required under CHIP to ensure CHIP children receive appropriate and medically necessary health care.

- **Plans must provide 24-hour-a-day, 7 day-a-week appropriate urgent, emergent, and triage services. Plans are required to have written policies and procedures that they communicate to providers, and plans are required to review their policies and procedures annually.**
- **Plans must ensure and monitor the availability of an after-hours call-in system to triage urgent and emergent call from clients.**
- **Plans must assure access to services according to the following time standards:**
  - **Immediately for emergency medical services. Within 24 hours for emergency dental, mental health, or chemical dependency services.**
  - **Within 48 hours for urgent medical, mental health, or chemical dependency services. Within one to two weeks for urgent dental services.**
  - **Within four weeks, or within the community standard, for well care for preventive or non emergent medical services.**

- **Within two weeks of patient request for intake assessment for mental health or chemical dependency services.**
- **Within twelve weeks, or the community standard, for dental services.**

For CHIP services provided on a FFS basis, all utilization review requirements of Title XIX and the 1115 Demonstration apply. The Quality Improvement Organization (QIO) contractor reviews inpatient hospital services. OHA requires prior authorization for certain services according to OHP Medicaid FFS protocols and claims are subject to SURS post-payment review.

Section 4. Eligibility Standards and Methodology

Guidance: The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, describe how they will be applied and under what circumstances they will be applied.

States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☐ **Eligibility for Medicaid Expansion Program**

4.0.1. Ages of each eligibility group and the income standard for that group:
The CS3 form supersedes this section

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☐ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
The CS9 form supersedes this section.

4.1.1 ☒ Geographic area served by the Plan if less than Statewide:
The CS9 form supersedes this section

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:
The CS9 form supersedes this section

4.1.3 ☒ Income of each separate eligibility group (if applicable):
The CS9 form supersedes this section

4.1.4 ☒ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):
The CS15 form supersedes this section

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state): **The CS17 form supersedes this section.**

4.1.6 ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility): **Not applicable**

4.1.7 ☒ Access to or coverage under other health coverage:
A child must be uninsured at the date of eligibility for the CHIP program.

4.1.8 ☒ Duration of eligibility:
The CS27 form supersedes this section

4.1.9 ☐ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required. **The CS9 form supersedes this section**

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility:
The CS27 form supersedes this section

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1)"lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1.1-LR ☐ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:
A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the

status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:
- (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
- (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
- (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
- (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
- (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
- (vi) Aliens currently in deferred action status; or
- (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA(8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C.§1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women
☐ Elected for children under age

4.1.1-LR ☐ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

- **4.2.1.** ☒ These standards do not discriminate on the basis of diagnosis.
- **4.2.2.** ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
- **4.2.3**. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

- **4.2.1-DS** ☐ These standards do not discriminate on the basis of diagnosis.
- **4.2.2-DS** ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- **4.2.3-DS** ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment.

The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

At the State's discretion, additional time may be allowed for beneficiaries living and/or working in Governor or FEMA declared disaster area to complete the renewal process.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1 Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

☒ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☐ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

The CS15 supersedes this section

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and

other applicable criteria that will describe the State's ability to make assurances. (Sections 2102)(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4 Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.
The CS24 form supersedes this section.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102)(b)(3)(B)) (42CFR, 457.350(a)(2))
See 4.4.1 above

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR, 431.636(b)(4)).

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR 457.810(a)-(c))

OHA has specific measures to prevent the clients from substituting CHIP coverage for group health coverage. The first measure is that persons covered by private health insurance are not eligible for benefits under CHIP. 7.2.2

OHA requires that insurance information on the persons seeking medical assistance coverage be provided on the application for CHIP as a measure to avoid substitution for group health coverage. OHA enrollees' TPR information is maintained in the MMIS system. In addition to self reported insurance information, the OHP Central Processing Center receives TPR

insurance information from providers which is verified by Central Processing staff. Eligibility staff also reviews pay stub information that may also indicate whether dependent health insurance is being deducted from the employee paycheck. The State monitors substitution under its Quality Control and Quality Assurance process to analyze the extent to which an applicant drops other health plan coverage. Trends are monitored to ensure that the policy is consistently applied throughout the program.

Targeted, low-income children of employees of the State of Oregon, who are eligible for employer sponsored insurance benefits, are not eligible for CHIP coverage since the State provides coverage of dependents.

The OHP Central Processing Center conducts standardized audits on an ongoing basis to review eligibility determinations to ensure that children who are Medicaid eligible, or who have private coverage are not enrolled in CHIP. The Quality Assurance Unit at OHP Central Processing conducts random audits on an ongoing basis of eligibility determinations to monitor the integrity of determinations. All eligibility elements are reviewed during this process, including assessment of the client's access to TPR and the substitution of coverage.

The Authority will conduct a biennial review of the Oregon Health Insurance Survey (OHIS) which looks at if a person was uninsured at the time of the interview, (there are questions asked about type of previous coverage, why their coverage ended, and how long they have been without coverage). Determine the percent of enrollees who dropped group health insurance without good cause in order to gain eligibility for CHP. If substitution exceeds 10 %, OHA will collaborate with CMS to identify a strategy to reduce substitution.

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

4.4.5 ☐ Child health assistance is provided to targeted low-income children in the

State who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))
OHA.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs

(i.e., Medicaid and state-only child health insurance):
As part of the outreach effort, the Oregon Health Authority plan to conduct a number of training sessions across the state. These training sessions focus on getting timely and accurate information about Healthy Kids into the hands of local community partners who have extensive contact with clients. Activities will target children eligible as the result of covering higher income levels, but also attempt to reach children at lower income levels who are eligible for but not enrolled in current programs. The Oregon Health Authority, Department of Human Services or Cover Oregon will develop and distribute educational materials for parents that focus on the importance of obtaining health coverage for their children and receiving preventive services.

Children from birth to age 6 with family incomes less than 133% of the federal poverty level (FPL) and children 6-18 with family incomes up to 133% of the FPL are eligible for coverage under the Oregon Health Plan Medicaid Demonstration.

OHP Medicaid and CHIP applications and application assistance are available at the 64 DHS Children, Adults and Families Division (CAF) branch offices throughout the state and at 56 Aged and Physically Disabled field offices. A well-publicized 800 number to the OHP Medicaid/CHIP Application Center is also available. The Application Center mails applications on request and helps callers in completing OHP applications and related forms. Applications may also be obtained and submitted on line via the Internet, through outreach locations at FQHCs, Tribal health clinics, DSH hospitals, Healthy Start, local health departments and Certified Application Assistance Organizations. Brochures outlining the services and eligibility requirements and containing the Application Center toll-free number and Web address are widely available in provider offices, libraries and other community distribution points throughout the state. The toll-free number for the Application Center also appears in the white pages of telephone directories throughout the state. Information about OHP Medicaid/CHIP services, eligibility requirements and processes is also available on the OHA website.

VISTA Health Links Project
VISTA volunteers work in many counties throughout the state. As a part of their activities to ensure public health systems and programs work well together for the women and children they serve, these volunteers provide clients assistance and information on the Oregon Health Plan, immunizations, prenatal care and other health issues/concerns. The WIC program has the broadest client base of the VISTA Health Links partner programs, and is often the gateway service for women and

children. Therefore, a good deal of the VISTA Health Links Project focus is around developing outreach efforts and systems to promote immunizations, OHP registration and early prenatal care access among WIC clients.

Community-Based Application Assistance Project
This program, started in January 1998, allows local health departments, Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC) and Tribal Health Clinics to distribute OHP Medicaid/CHIP applications and to give on-site assistance with completion of the OHP application for children, pregnant women and their families. Currently OHA has 200 outreach sites located throughout the state.

Hospital Hold-CHIP OHP Plus
If an uninsured patient is admitted to a hospital, the hospital may fax a Hospital Hold form for the patient to the OHP Medicaid/CHIP Application Center within 24 hours of the admission, or by the next working day. The intent of this program is to allow people who receive care in a hospital (inpatient only) to secure a date of request for the Medicaid/CHIP program application although they cannot physically reach a phone or a DHS branch. An OHP Medicaid/CHIP application is sent to the patient. For those who complete and return the application and are determined eligible for OHP Medicaid or CHIP, their eligibility is retroactive to the date of request. The original date of request is honored if the application is received within 45 days from the date of request.

SAFENET
SAFENET is a community partnership program that provides a statewide toll free information/referral phone line for Oregonians. It is the state's Maternal and Child Health (MCH) hotline, designed to link low-income Oregon residents with health care services within their communities, including information on the Oregon Health Plan.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all

uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

No public-private partnerships currently exist in Oregon

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. Section 2102(a)(3) and 2102(c)(2) and 2102(b)(3)(E))(42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts -- particularly new enrollment outreach efforts will be coordinated with and improve upon existing State efforts described in Section 5.2.

Oregon conducts the following activities to coordinate the Title V Maternal Child Health Program with OHP-CHIP:

The Child Development and Rehabilitation Center (CDRC) administers the Oregon Services to Children with Special Health Needs (OSCSHN) Title V Program at the Oregon Health and Sciences University (OHSU). The OSCSHN Financial Assistance Program provides financial assistance to families who meet the financial eligibility criteria at three times the federal poverty level and whose child has a qualifying medical diagnosis. Financial counselors screen families to determine program eligibility and make referrals to OHP including Medicaid or CHIP when appropriate. OSCSHN staff, conduct follow-up calls to families referred to the OHP to determine the status of applications and to provide assistance when needed. This effort has resulted in more families qualifying for benefits and cost savings to the OSCSHN budget.

The OHA Public Health Division, Office of Family Health Services (OFHS) serves as the state Title V Agency and continues to work closely with OHAs Medicaid/ CHIP Division(HSD). The OFHS maintains an agreement with HSDOHA for a community immunization program and to purchase vaccines for children enrolled in CHIP, for joint management of the Section 1115 Demonstration Family Planning Expansion Project, and for the MCH Hotline, SafeNet, which is contracted to the Multnomah County Health Department. Other coordination efforts include lead screening, preschool and adolescent immunization, vaccines for children, school based health centers, Oregon MothersCare, Babies First and CaCoon.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to

provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

5.3 Strategies

Guidance: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90) The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

Outreach for CHIP will be incorporated into existing OHP Medicaid outreach activities, including:

- **VISTA Health Links;**
- **DSHs Hospitals, FQHCs and tribal health clinics local health departments.**
- **Hospital hold;**
- **SAFENET;**
- **Outreach through Healthy Start.**

Programs above are described in more detail in Section 5.1.1

Application Assistance:

To help more children, teens, individuals, and families in Oregon to get and maintain health insurance, the Oregon Health Authority (OHA) and Cover Oregon (Oregon's Insurance Exchange) joined forces to administer a community partner program. Through the program, trained community partners (application assisters) will provide education and outreach and help children, teens, and families enroll in public programs and commercial insurance plans available through Cover Oregon. Grant opportunities will be available to interested organizations.

The types of organizations that can be a grantee are health advocacy groups, cultural specific organizations, Faith based groups, community based organizations, community clinics, libraries, housing authorities, migrant organizations, etc. There will be a competitive bid process as grant opportunities are available to any organizations that qualify to participate.

OHA will also work with community partners that don't receive grant funding directly from the initiative, including local governments, hospitals, coalitions, etc. Additionally, provider assisters that already provide application assistance through contracts with the Division of Medical Assistance Programs (OHA). All grantee and volunteer agreements will include conflict of interest, privacy and security, enrollment assistance, and either cultural competency or equitable service standards.

OHA will target potential partnerships with community-based organizations that are diverse and have expertise serving hard-to-reach, non-English speaking, geographically isolated, and underserved populations. Community partner organizations will:

- **Focus on conducting enrollment assistance and outreach to families accessing public and private health insurance coverage in the individual market;**
- **Develop local outreach campaigns tied to the overall marketing effort;**
- **Offer consumer assistance with all aspects of eligibility, enrollment, appeals, and renewals;**
- **Contribute to the overall consumer experience;**
- **Collaborate with other community partners as well as insurance agents, and;**
- **Address misconceptions in local communities about public and private programs and the ACA**

Community partner organizations may have staff and/or volunteers trained as application assisters. Application assisters will lead individuals and families through the entire process of eligibility and enrollment for public and private health coverage. "Application Assister" encompasses what the Affordable Care Act and other states refer to as navigators, in-person assisters, and application counselors. All application assisters must attend training and pass a certification exam. Additionally, application assisters must:

- **Be covered by the organization's general liability and automobile insurance,**
- **Pass a criminal background check,**
- **Complete an online pre-requisite Cover Oregon overview,**
- **Attend enrollment assistance training annually, and**
- **Pass an annual certification exam.**

Grantees will target geographic areas with high rates of eligible but un-enrolled children, teens, individual, and families including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health insurance, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness. Grant funds are intended for staff time, local travel, and other expenses necessary to reach and provide assistance to children, teens, individuals, and families. OHA will provide

technical assistance and training, publications and other promotional materials.

Outreach and Enrollment Grants:
The Targeted Outreach and Enrollment Grant Program is designed to provide culturally-specific and targeted outreach and direct application assistance to aid families in racial, ethnic and language minority communities, living in geographic isolation or with additional access barriers to enroll their children into the Healthy Kids program. The Outreach and Enrollment Grantee will target geographic areas with high rates of eligible but unenrolled children, including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness. Grant funds are intended for staff time, local travel, and other expenses necessary to reach and provide assistance to targeted families with children. OHA will provide technical assistance and training, publications and other promotional materials

The targeted Outreach and Enrollment Grant program will provide funding opportunities to community organizations that apply and are selected for an award. The funds must be used for activities that will lead to enrollment of children into the Oregon Health Plan for both Medicaid and CHIP. Activities funded may include, but are not limited to, community education, application assistance, and participation in community events. Outreach grants will be awarded to community organizations specifically targeting enrollment of children in racial, ethnic and language minority communities; living in geographic isolation; and/or with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency; and those experiencing homelessness.

The criteria used to award an outreach and enrollment grant are:

(1) Ability to Target geographic areas with high rates of eligible but unenrolled children, including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness;
(2) Demonstrate that they have access to, and credibility with, target populations; and
(3) Demonstrate that they have the ability to address barriers to enrollment, such as a lack of awareness, stigma concerns and punitive fears or cultural barriers.
(4) Are not currently a CAAO participating in the AAP.

Outreach and Enrollment Grants will begin effective upon CMS approval on or after October 1, 2009. The grant will be for the balance of state fiscal year 2010 and renewable for a second year, based on performance. Grants will range from $20,000 to $80,000 a year. We anticipate awarding approximately 20 to 40 grants in the first biennium. Each grantee will have enrollment

targets that they have proposed in their application and will have been approved by Office of Healthy Kids. Grantees will be required to provide monthly reports on their progress. Fund disbursement will be contingent upon demonstrating progress toward their goals. The Office of Healthy Kids will be fully staffed with at least one FTE monitoring their progress and providing technical assistance.

Outreach and Enrollment Grant agreement statement of work includes, but is not limited to: Identifying its target population(s);

- **Distributing OHA-approved promotional, educational and marketing materials to its targeted population**
- **Completing application assistance training, provided by OHA;**
- **Participating in meetings and conferences as requested by OHA;**
- **Assisting its targeted population in completing the enrollment process into the Healthy Kids program, in accordance with the application assistance training;**
- **Collaborating with local community organizations and establishing information-sharing processes as needed.**
- **Submitting its progress to OHA on monthly and annual basis according to reporting requirements specified by OHA, including the number of families contacted and the number of children enrolled successfully;**
- **Conducting outreach that is results driven and connected to actual enrollment and retention of children; and**
- **Developing strategies to overcome barriers that families in the target population may have, and establishing relationships of trust to effectively support enrollment;**

Section 6. **Coverage Requirements for Children's Health Insurance**

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;

- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
    - coverage of prescription drugs,
    - mental health services,
    - vision services and
    - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time

to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage**. (Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☒ Coverage the same as Medicaid State plan
6.1.4.2. ☒ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive

state-based coverage applicable only New York, Pennsylvania, or Florida (under □457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in □457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in□ 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If

an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)
***Applicable for from Conception to end of pregnancy population - When any grouping below is provided only if medically necessary or limited it is identified with *L/MN.**

6.2.1. ☒ Inpatient services (Section 2110(a)(1))
6.2.2. ☒ Outpatient services (Section 2110(a)(2))
6.2.3. ☒ Physician services (Section 2110(a)(3))
6.2.4. ☒ Surgical services (Section 2110(a)(4)) ***L/MN**
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12)) ***L/MN**
6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13)) ***L/MN**

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☒ Nursing care services (Section 2110(a)(15))

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) ***L/MN**

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18)) ***L/MN**

6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19)) ***L/MN**

6.2.20. ☒ Case management services (Section 2110(a)(20))

6.2.21. ☐ Care coordination services (Section 2110(a)(21))

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22)) ***L/MN**

6.2.23. ☐ Hospice care (Section 2110(a)(23))

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24)) ***L/MN**

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☒ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28)) ***L/MN**

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health

plan:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
    - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☒ American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify:)
☐ Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))
See section 6.4 for a list of additional screening tools.

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

The majority of the Oregon Health Plan population are enrolled in a Managed Care Entity called Coordinated Care Organizations (CCO). CCOs. require the use of age-appropriate screenings for behavioral health in primary care clinics. OHA publishes various newsletters that providers, members and general public can subscribe to. Provider Matters is a newsletter for OHP providers which includes updates about fee-for service claim processing, policy and resources. This includes information on current assessment, screening, and authorizations processes and instructions. The newsletters are archived and available on the OHA – OHP Provider Matters webpage.

OHA maintains several webpages with resources for providers. There is a specific page dedicated to Tools for BH Providers and has links to toolkits, trainings and updated information The Healthcare Partner Resource page has specific section for BH providers including tools and guidance on responding to new BH regulations and updates.

OHA also utilizes stakeholder groups, provider services call center and MMIS banner messages to disseminate information and technical support to providers.

For CCO contracts information about screening and assessment policies and practices are disseminated the same way. OHA distributes communications through their CCO Operations team and monthly Director's meetings. The topics are chosen by OHA to bring attention to provider information that also goes out in written form to the CCOs. CCOs and providers enrolled with CCOs are encouraged to access the same platforms discussed above for FFS providers. The CCO contract also requires them to develop and implement infrastructure and support for sharing information, coordinating care and monitoring results with providers.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Includes structured counseling, motivational enhancement, case management, care-coordination, psychotherapy and relapse prevention. Psychosocial treatment is managed by a Retroactive Review process.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Intensive tobacco cessation treatment includes; Multiple treatment encounters; Behavioral and all FDA approved tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum); Individual or group counseling, six minutes or greater. There are no limitations for tobacco cessation counseling. Individuals are allowed up to 4 quit attempts per 12 month period and as many as 10 FTF counseling sessions per quite attempt in a 3 month period with unlimited calls to the quit line. Oregon follows the recommendations of the most current U.S. Public Health Service (USPHS) clinical guidelines.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

FDA approved medications used in opioid addiction treatment are *agonists*, *partial agonists,* and *antagonists (*methadone, naltrexone, and buprenorphine). These drugs are used in conjunction with counseling and behavioral therapies to provide a whole-patient approach to the treatment. MAT is clinically driven with a focus on individualized patient care identified in their integrated service and

support plan (ISSP). There are no hard limitations, quantity and treatment duration is based on medical necessity and determined by the individual's needs and documented in their assessments and treatment plans, including counseling and behavioral therapies provided.

MAT drugs and biologicals:
All FDA approved medications are available. Supply limits, early refill thresholds and therapeutic duplication are enforced by Prior authorization (PA) and Quantity limits.

- Prior authorization is required for high-dose products to prevent inappropriate and off-label use.

If presented with a prescription of an opioid, a licensed pharmacist may provide counseling and prescribe naloxone with the necessary medical supplies to administer.

6.3.2.3.2- BH ☒ Alcohol Use Disorder

Oregon includes coverage for all substance use disorders, including alcohol. Coverage include; screening, assessment, individual counseling, group counseling, individual family and/or couple counseling, group family and/or couple counseling, care coordination, medication assisted treatment, medication management, collection and handling of specimens for substance analysis, interpretation services, acupuncture, detoxification and peer support. Services are individualized patient care identified in their ISSP.

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Peer Support services can be provided to individuals who are under the consultation, facilitation or supervision of a competent SUDs treatment professional who understands rehabilitation and recovery. Peer Support services promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills in order to facilitate the recovery of others with substance use disorders. Peer services

include self-help support groups by sharing the peer counselor's own life experiences related to SUDs and will build support mechanisms that enhance the consumers' recovery and restores their ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc.). Services provided by peer supports are described in the individualized ISSP which uses a person centered planning process to promote participant ownership of the plan of care and delineates specific goals. Peer services require prior authorization.

6.3.2.5- BH ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Specialized combination of services provided to individuals under the age of 21 in the community or at the individual's home to provide for stabilization and long term treatment. These services may include a combination of individual and family therapy, skills training, medication management, peer support, case management, and in-person crisis response as indicated in the Person-Centered Service Plan. Services are intended to provide intensive interventions in the community and provide additional community-based options to residential treatment. Prior Authorization is required for these services.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Oregon covers alcohol and/or drug services under intensive outpatient treatment programs based on an individualized ISSP treatment plan. Coverage as with all OHP Mental and SUD rehabilitation may include; screening, assessment, individual counseling, group counseling, individual family and/or couple counseling, group family and/or couple counseling, care coordination, medication assisted treatment, medication management, collection and handling of specimens for substance analysis, interpretation services, acupuncture, detoxification and peer support as identified in an individual ISSP.

6.3.2.9- BH ☒ Psychosocial rehabilitation

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Coverage as with all OHP Mental rehabilitation may include; screening, assessment, individual counseling, group counseling, individual family and/or couple counseling, group family and/or couple counseling, care coordination, medication assisted treatment, medication management, collection and handling of specimens for substance analysis, interpretation services, acupuncture, detoxification and peer support as identified in an individual ISSP. Services shall be subject to periodic utilization review to determine medical appropriateness.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Psychiatric Day Treatment Services (PDTS) is provided to children who remain at home with a parent, guardian, or foster parent by qualified mental health professionals and qualified mental health associates in consultation with a psychiatrist. An education program is provided, and children are screened for an Individual Education Plan, Personal Education Plan, or Individual Family Service Plan. PDTS programs are staffed at a clinical staffing ratio of at least one QMHP or QMHA for three children.

6.3.3.1- BH ☒ Partial Hospitalization

Provided for: ☒ Mental Health ☐ Substance Use Disorder

Partial hospitalization and intensive outpatient levels of care provide patients a structured day treatment setting where they can work on their treatment goals. Services may include psychotherapeutic groups, focusing on coping skills involving supports and crisis planning, and safety and stabilization. Eligible providers are certified by OHA and standards required by Oregon Administrative Rules Chapter 309 Division 039 and 019.

For individuals with substance use disorders who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include partial hospitalization if necessary.

Partial hospitalization services could include, daily group therapy for mental health conditions, individual counseling with a primary therapist, family therapy, as appropriate

to the individual needs of the client, Psychotropic medication management or monitoring and skills training, vocational training, socialization or structured recreational/physical fitness activities.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Residential treatment on a per diem basis for behavior health issues in a hospital residential treatment program is designed to provide a 24-hour group living situation in which the patient receives treatment under the care of a physician. This does not include daily room and board. Prior Authorization is required for this service.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Short-term residential treatment is typically less than 30 days. This applies to a residential treatment program for behavior health issues, which could include A&D treatment, that is not part of a hospital but provides a 24-hour group living situation in which the patient receives treatment and does not include daily room and board.

Long-term residential treatment is typically more than 30 days. This applies to a residential treatment program for behavioral health issues, which could include A&D treatment, that are neither medical nor acute in nature. This service is per diem, not including daily room and board. Long-term residential treatment requires prior authorization where the Division authorizes admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation.

6.3.4.2- BH ☒ Detoxification

Provided for: ☒ Substance Use Disorder

Clinically managed detoxification is an organized service that provides 24-hour structure, support, supervision, and observation for individuals who are intoxicated or experiencing withdrawal symptoms. Emphasis is on peer and social support, this level of care does not

require medical professionals. Providers include peer support and other non-clinical staff.

Medically monitored detoxification is delivered by licensed medical and nursing professionals, who have specialized training in substance use disorders and which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. This level of care is for individuals whose withdrawal signs and symptoms are sufficiently severe to require medical professionals but not an acute care general hospital. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section. Services are subject to periodic utilization review to determine medical appropriateness.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility-based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Acute care emergency department services provided in a hospital are a covered service without limitations or review Emergency service admissions into residential treatment are also covered and are made by the team responsible for a plan of care as described in CFR 441.156 within 14 days from the date of admission.

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Evaluation and treatment of mental health crisis to individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Stabilization services include short-term face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional. Stabilization services may be provided prior to an intake evaluation for mental health services. Providers authorized to provide these services include LMP, QMHP and mental

health interns under appropriate supervision. These services are managed under retrospective review.

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Continuing care services of appropriate duration and are designed to maximize recovery opportunities. The services can include: Reintegration services and coordination with family and schools; Youth dominated self-help groups where available; Referral to emancipation services when appropriate; Referral to physical or sexual abuse counseling and support services when appropriate; and Referral for peer delivered services

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

In Oregon "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.
Activities include assessment and ongoing re-assessment, assists in treatment goal planning, integrated treatment planning, resource identification, referral and linkage to rehabilitative services and informal resources such as family and self- help support, and collaborative development of individualized services that promote continuity of care. These specialized activities are intended to promote treatment retention and to minimize the risk of relapse or unplanned re-admission and to increase the community tenure for the individual. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Wraparound program is available to youth served in two or more child-serving systems and experiencing complex needs, obtain a mental health assessment within 60 days of Wraparound referral. For those enrolled in managed care requires prior approval by a Wraparound Review Committee convened by the CCO or by an authorized Tribal entity. SUD services are included as a potential complex need and the provider is expected to

help coordinate SUD services if that is an identified need.

6.3.7.2- BH ☐ Care transition services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

In Oregon BH Case Management means the services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, entitlement, and other applicable services. It includes both mental health and SUDs case management.
BH Case Management included in general case management in an effort to improve care and to contain costs by having one party manage or coordinate all care delivered to a patient that usually has certain complex illnesses or injuries, including mental and behavioral health issues. Case management may include, but is not limited to, the evaluation of a condition, the development and implementation of a plan of care, the coordination of medical resources, and the appropriate communication to all parties. Targeted case management is targeted to a specific population subgroup.

SUD Case management for patients needing services relating to alcohol or drug abuse provides assistance and care coordination based on the needs of the individual. The case manager assesses the needs of the patient, assists in developing plans to benefit the patient, as well as implementation of the plans, and reviews and evaluates the patient's status. Oregon will manage utilization consistent with analysis of Oregon and other states policies using a retrospective review process.

6.3.9- BH ☒ Other
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Personal Care Services: include a range of assistance, as developmentally appropriate, provided to persons with disabilities and chronic conditions which enables them to accomplish tasks, which they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing (redirecting) so that the person performs the task by him or herself.

Personal care assistance relates to performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs include; eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include; personal hygiene, light housework, laundry, meal preparation, transportation,

grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions.

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☒ Substance Use Disorders

☒ InterQual
☒ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☐ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)
☒ Mental Health ☐ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☒ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☐ Substance Use Disorders

Level of Service Inventory

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.
Strategy addressed above in 6.3.1.2. Oregon has a long history of coverage for behavioral and SUD. The services were part of the original 1995 1115 demonstration waiver for the Oregon Health Plan. Oregon continues working with provider organizations including our CCOs in current and new best practices as it relates to assessment tools. OHP coverage is the same for all populations whether CHIP or Medicaid.

Mental Health Evaluation and Treatment Services Assessments and treatment services, to prevent disease, disability, other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. Providers are currently reimbursed for assessments; reimbursement is sufficient to allow for provider training and tool purchase.

For MH rehabilitation services coordinated assessments and screenings include the intake process of the individual, a mental health assessment resulting in a diagnosis and completion of an integrated service and support plan (ISSP) with the individual's input in setting their treatment goals.

Providers are required to use the American Society of Addictions Medicine (ASAM) to assess placement needs associated with Substance Use Disorders (SUDs). CCOs are required to ensure employees or providers who are conducting assessments have the training and background necessary to evaluate the medical necessity for SUD services.

Providers are required to use the CANS to assess children services. CANS is a multipurpose tool that includes screening and assessment developed to support decision making, including level of care and service planning, to facilitate Quality Improvement initiatives, and to allow for the Monitoring of outcomes of services and supports. CCO contractors are required ensure those conducting the CANS has specific training. Only providers who have been certified by the Praed Foundation for administering the CANS Oregon (as found at https://www.schoox.com/login.php) shall administer CANS Oregon to Members.

Oregon has developed different strategies to communicate this information with providers. OHA publishes various newsletters that providers, members and general public can subscribe to. Provider Matters is a newsletter for OHP providers which includes updates about fee-for service claim processing, policy and resources. This includes information on current assessment, screening, and authorizations processes and instructions. The newsletters are archived and available on the OHA – OHP Provider Matters webpage.

OHA maintains several webpages with resources for providers. There is a specific page dedicated to Tools for BH Providers and has links to toolkits, trainings and updated information The Healthcare Partner Resource page has specific section for BH providers including tools and guidance on responding to new BH regulations and updates.

OHA also utilizes stakeholder groups, provider services call center and MMIS banner messages to disseminate information and offer technical support to providers.

For CCO contracts information about screening and assessment policies and practices are disseminated the same way. OHA distributes communications through their CCO Operations team and monthly Director's meetings. The topics are chosen by OHA to bring attention to provider information that also goes out in written form to the CCOs. CCOs and providers enrolled with CCOs are encouraged to access the same platforms discussed above for FFS providers. The CCO contract also requires them to develop and implement infrastructure and support for sharing information, coordinating care and monitoring results with providers.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment

and monitoring of children with chronic, complex or serious conditions.

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

☒ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. Previously 8.6

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered

benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD) 10

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☐ Yes

☒ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☐ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☐ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☐ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☐ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☐ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☐ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☐ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☐ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health

plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

The first step in the MHP analysis was to determine which services are defined as MH/SUD and which are M/S. MH/SUD services are those that are used to treat a MH/SUD diagnosis, and M/S services are those used to treat a M/S diagnosis. For the purpose of Oregon Medicaid's parity analysis, the current International Classification of Diseases (ICD-10) has been adopted for mapping conditions into M/S and MH/SUD buckets.

- **Mental health benefits means benefits for items or services for mental health conditions listed in ICD-10 Chapter 5 (F), except for subchapter 1 (F01-09, mental disorders due to known physiological conditions), subchapter 2 (F10-F19, Mental and Behavioral disorders due to psychoactive substance use) and subchapter 8 (Intellectual disabilities).**
- **Substance use disorder benefits means benefits for items or services for substance use disorder conditions listed in ICD-10 Chapter 5 (F) subchapter 2 (F10-F19, Mental and Behavioral disorders due to psychoactive substance use).**
- **Benefits used to treat all other ICD-10 diagnoses are considered medical/surgical**.

Benefits are assigned to M/S or MH/SUD groupings based on the ICD-10-CM diagnosis, not according to who is providing the service or which delivery system is being used. For example, an ER visit to address a MH/SUD diagnosis is considered a MH/SUD benefit and an ER visit to address a M/S diagnosis is considered an M/S benefit.
MH/SUD, and M/S benefits are then mapped into four classifications: inpatient, outpatient, prescription drug and emergency care. The mapping guide is attached.

6.2.3.1.1 MHPAEA The State assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☒ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☒ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical

benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☒ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan

year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a

classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☒ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☐ State

☐ Managed Care entities

☒ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☐ Managed Care entities

☒ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.3 The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4 Additional Purchase Options- If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the

10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10% limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10% limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.6.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR, 457.1010)

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010)A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☒ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described

in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA: Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☒ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") option under the State plan should also check box 6.5.3.

6.5.1 Vaccine coverage for targeted-low-income children.

☐ The State provides coverage for age-appropriate vaccines and their administration on accordance with the recommendations of the Advisory Committee in Immunization Practices (ACIP), without cost sharing. (Section 2103©(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).

6.5.2 Vaccine coverage for Targeted-low-income pregnant individuals.

☐ The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO# 23-003, issued June 27, 2023): (Section 2103(c)(12))

6.5.3 Vaccine coverage for from-conception-to-end of pregnancy population option.

☒ The State provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost sharing, to benefit the unborn child.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

For CHIP OHP Plus, OHA contracted coordinated care organizations, results of consumer satisfaction surveys, EQRO and site review identify areas that need system improvements in quality of or access to care. OHA measures well-baby care/child/adolescent care and childhood immunizations through the use of HEDIS performance measures. The results of these measures are reported by FCHP, as well as fee-for-service. In addition, access to primary care provider and measures of early childhood cavities prevention efforts are measured.

Health KidsConnect private option plans are licensed and regulated by the Department of Consumer and Business Services (DCBS), Oregon's insurance division. The regulations for Health insurers require the carriers to report annually to DCBS on grievance and appeals, utilization review policies, quality assessments activities and health promotion and disease prevention activities, including a summary of screening and prevention health care activities covered by the insurer, as well as the scope of the insurers network and to the accessibility of services. Health insurers measure well-baby care/child/adolescent care and childhood immunizations through the use of HEDIS performance measures.

7.1.1. ☒ Quality standards

7.1.2. ☒ Performance measurement

7.1.2 (a) ☒ CHIPRA Quality Core Set

7.1.2 (b) ☐ Other

7.1.3. ☒ Information strategies

7.1.4. ☒ Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

CHIP OHP Plus: CHIP services will be provided through Oregon's existing OHP Medicaid Demonstration delivery system. The managed care plans are contracted directly with OHA (described in Section 3.1). Since 1994, health plans that contract with the state to provide Title XIX services have been required to adhere to established quality assurance methods and protocols. As the state of the art of managed care quality assurance has changed and become more sophisticated, so have Oregon's requirements for plan participation. Activities of the OHP Medicaid Demonstration quality improvement program extend to CHIP OHP Plus coverage. This assures CHIP OHP Plus members will receive the same quality of care and access to care currently provided to OHP Medicaid members. Specific studies of the quality of care and access to care of CHIP OHP Plus members are conducted within the context of ongoing OHA quality improvement and evaluation efforts. As described in OHAs Oregon Health Plan Administrative Rules and the General Rules, Coordinated Care Organizations (CCOs) that contract with OHA must meet specific mandatory obligations designed to assure quality, medically appropriate care for all OHP enrollees. The data specifications and reporting requirements outlined in the Rules are consistent with CMS's quality initiatives for Medicaid managed care. All services provided to children enrolled in Oregon's CHIP OHP Plus program will meet the same standards of quality assurance and medically appropriate care as currently provided by OHP Medicaid. With respect to health care delivery systems, OHA has many contractual requirements for plan participation. PHPs must meet various quality assurance reporting requirements, including the following:

Reporting Area Quality Assurance Requirement

Plan Infrastructure and Management

Solvency plan and financial reporting

- **Medical and dental record keeping system**
- **Utilization control requirements and review procedures**
- **Credentialing and recredentialing procedures**
- **Information materials for the orientation of new members and the continuing education of existing members**
- **Provider compensation and turnover rates**

Access/Availability Utilization of Medically Appropriate Covered Services, including:

- **Inpatient/Outpatient care;**
- **Maternity and newborn care;**
- **Ambulatory care;**
- **Preventive care; and**
- **Emergency services**
- **Sufficient quantity of providers to ensure adequate capacity**
- **24-hour-a-day, 7-day-a-week emergency and urgent care services**
- **Language and transportation services**
- **Medical Case Management services**
- **ADA compliant physical access to facilities and providers**
- **Community Standards governing scheduling, rescheduling and waiting time for scheduled appointments**
- **Client Referral system**

Reporting Area Quality Assurance Requirement
Quality of Care

- **Documented policies and procedures for member care**
- **External review of policies and procedures relating to member care and medical record review for quality of care**
- **Internal Quality Assurance and Quality Improvement programs based on written policies, standards and procedures**
- **Quality assurance committee structure and membership guidelines**

Member Rights

- **Due process rights; including a formal complaints and hearings process**
- **Rights to informed consent**
- **Rights to treatment with dignity and respect**
- **Other processes establishing and maintaining rights to adequate medical care**

Clinical Measures and Utilization
The Health Plan Employers Data Information Set (HEDIS) and statewide goals described in Oregon Shines II, the state's 20-year strategic plan, serves as the basis on which CHIP OHP Plus health care is assessed for quality and appropriateness of care. OHA collects the following health measures specific to the population of OHP clients under 19 years of age:

- **Access to Primary Care Provider**
- **Childhood Immunizations**
- **Well-Baby, Child and Adolescent Visits**
- **Annual dental visit**

Over 85 percent of CHIP OHP Plus children are enrolled in managed care. OHA evaluates and monitors the measures listed above for each health plan. These measures are used as part of our periodic on-site reviews of each health plan to promote access to necessary services. OHA does not currently sanction plans for not meeting minimum performance levels for these measures. However, OHA has both a Quality Improvement Coordinator and a coordinated care organization coordinator assigned to each plan to monitor access to services and performance on these critical indicators. If problems are encountered, these staff members work with the health plans to establish and monitor corrective action plans in order to achieve acceptable performance.

Contracted health plans are required to have written policies and procedures and monitoring systems that provide for emergency and urgent services for all OHA Members on a 24-hour, 7-day-a-week basis.
Contracted health plans are required to have written policies, procedures and monitoring systems that ensure the provision of Case Management Services for all OHP clients, to coordinate and manage services, and to ensure that referrals made are noted in the patient's clinical record. Plans are required to develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable Alternative Care Settings, for all services covered by agreements with OHA. Health plans must ensure that access to and quality of care provided in all referral settings is monitored.

Other Efforts to Improve Quality of and Access to OHP Services:

Quality
OHA coordinates the activities of the OHAs' Oregon Health Plan Quality Improvement Committee (OHPQIC). The OHPQIC is responsible for advising and

guiding the quality improvement efforts of all administrative components of the OHP and will serve a similar role in assessing the CHIP OHP Plus. The overall mechanism for quality improvement, administered by OHA requires PHPs to have an active Quality Improvement Process (QIP) in place and integrated with other management functions. QIP performance is evaluated annually and involves review against standards in the following areas:

- **Member Care is measured against current, relevant, criteria for care.**
- **Medical and Dental Records are reviewed for structure and completeness.**
- **Quality Improvement Program Policies and Standards are reviewed and refined to meet changing conditions and needs.**
- **Comorbidities and Special Needs are reviewed before denial of a service and review of notices of denials.**
- **Member Access to Service and Utilization of Service is evaluated by site examination of PHP policies and practices and encounter data claim validation.**
- **Member Educational Plans and Provider Information are evaluated by site examination of PHP policies, practices and materials.**
- **Preventive care, adequacy of medical or dental record keeping;**
- **Operation and outcome of referral procedures;**
- **Medication reviews;**
- **Appointment systems;**
- **After-hours call-in system;**
- **Emergency services;**
- **Denials of service;**
- **PHP-initiated disenrollments;**
- **The access plan and out-of-plan access;**
- **Encounter data management**; and
- **Timeliness and appropriateness of referrals.**
- **OHA also reviews for compliance with its Administrative Rules which set standards for access, provider credentialing and other structural measures of quality.**

Oregon's PHPs have adopted selected elements of NCQA standards as the basis for their quality improvement programs, credentialing systems, record keeping, and utilization review. OHA also contracts with an External Quality Review Organization (EQRO) for medical record review of a representative sample of OHP Medicaid clients to determine the quality of care they receive. Recent EQRO studies include prenatal care, diabetes management and depression.

Access and Member Satisfaction
OHA conducts surveys of members to determine satisfaction with access to medical services in terms of distance and appointment availability. Americans with Disabilities Act (ADA) access is reviewed in the survey of adult populations and children's access to service with the children's form of the Consumer Assessment of Health Plans Study (CAHPS) survey. Oregon has established a biennial member satisfaction survey using the nationally standardized CAHPS instrument to assess members experiences of access, satisfaction, and system performance.

Quality Assurance and Utilization Review
Oregon has built on the successful design, implementation, and improvement of the OHP Quality Improvement Program for CHIP OHP Plus. PHPs monitor the quality of care using a number of aspects of care, including outcomes of selected procedures. Each PHP is responsible for the maintenance of the organizational and methodological structures (such as Quality Improvement Committees and reviews of adverse events) necessary to ensure the quality and appropriateness of care.

Preventive Care
Oregon's emphasis on primary prevention is best demonstrated through the activities of Project: PREVENTION! a management and quality initiative developed by OHA in the Spring of 1996 in partnership with the Public Health Division and the OHP managed care plans. The goal of Project: PREVENTION! is to assure the presence and effectiveness of preventive health care services for OHP clients. A task force identified and recommended appropriate preventive health practice measures for individual plans to target and accelerate. In addition, Project: PREVENTION! developed a joint-venture partnership with OHP plans, the Public Health Division, non-OHP plans and county health departments on one unified statewide measure, an electronic pediatric immunization registry, Immunization ALERT. Immunization ALERT is a comprehensive immunization registry designed to give providers access to current and complete childhood immunization records despite changes in family residence, health insurance and choice of health provider if the child remains in Oregon.

Project: PREVENTION! supports a statewide tobacco cessation effort that involves partnership with medical and dental managed care plans, the Public Health Division and the Tobacco Free Coalition of Oregon. Central to the tobacco cessation project is the collective identification, education, and treatment of tobacco users. Medical and dental providers developed programs to help prevent children and adults from starting to use tobacco and have increased their efforts to help them quit. Project: PREVENTION! also adopted HEDIS technical standards for use in

the measurement of childhood and adolescent immunization status, diabetes and asthma.

In 2001 Project: PREVENTION! adopted Early Childhood Cavities Prevention as the focus for prevention efforts. These efforts are ongoing with the FCHPs and DCOs.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))
CHIP OHP Plus: CCOs that contract with OHA are required to follow established rules concerning access and availability of covered services outlined in the Oregon Health Plan Administrative Rules under rule OAR 410-141-0220: Oregon Health Plan Prepaid Health Plan Accessibility. Requirements of this rule include:

- **Written policies and procedures that establish standards for access, capacity, risk assessment, interpreter services, and ADA compliant accommodation to ensure access to health care services to all OHP members**
- **Geographic proximity of facilities and appointment wait times as determined by the prevailing Community Standard**
- **Sufficient provider panels and networks to ensure adequate service capacity to provide availability of, and timely access to, medically appropriate services**
- **Professional expertise among providers to treat or otherwise accommodate the full range of medical, dental or mental health conditions experienced by OHP members**
- **Monitoring systems to assure access to services according to time standards as indicated by the nature of the appointment including:**
- **Emergency care – Immediately for physical. Within 24 hours for dental, mental, or chemical dependency.**
- **Urgent care – Within 48 hours for physical, mental or chemical dependency, as indicated. Within one to two weeks for dental.**
- **Well Care, Routine, Preventive or Non-urgent – Within four weeks or the Community Standard for physical. Intake assessment for mental or chemical dependency within two weeks of patient request. Within twelve weeks for dental.**
- **Maintenance of 24-hour telephone coverage with a live operator (not a recording) guided by established standards pertaining to Primary Care Provider**

(PCP) call-back and back-up in the areas of:

- **Emergency, urgent, and routine issues**
- **Internal Medicine, Family Practice, OB/Gyn, and Pediatrics**
- **Interpretive services after office hours**

OHA and the PHPs monitor all access issues from both the planning and implementation perspective. Regular reports, site inspections, internal and external audits, and consumer satisfaction surveys serve to validate the effectiveness and timeliness of access to covered medical services.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

CHIP OHP Plus: PHPs are required to assure access to the services they provide including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to OHA Members in terms of timeliness, amount, duration and scope as those services are to non-OHA persons within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to OHA and provide reasonable alternatives for Members to access care that must be approved by OHA. PHPs have a monitoring system that demonstrates to OHA, as applicable, that the plan has surveyed and monitored for equal access of OHA Members to referral providers pharmacy, hospital, vision and ancillary services.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

CHIP OHP Plus: OHA requires PHPs to make a determination on authorization requests within two working days of receipt of an authorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in skilled nursing facility. Authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If an authorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72 hour supply if the medical need for the drug is immediate.

For all other pre-authorization requests, PHPs shall notify providers of an approval,

a denial or a need for further information within 14 calendar working days of receipt of the request.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☐ Yes
8.1.2. ☒ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. ☐ Premiums:
8.2.2. ☐ Deductibles:
8.2.3. ☐ Coinsurance or copayments:
8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:
8.2.2-DS ☐ Deductibles:
8.2.3-DS ☐ Coinsurance or copayments:
8.2.4-DS ☐ Other:

8.3 Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(A)) (42CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4 The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
8.4.3 ☐ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☐ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds

the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5 Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6 Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

8.7 Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1 Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of

cost-sharing charges. (42CFR 457.570(b))

☐ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

The strategic objective for Oregon's Children's Health Insurance Program (CHIP)

is to expand coverage of the Oregon Health Plan (OHP) to include eligible low-income children. The current OHP delivery system assures quality medical care to the Medicaid and CHIP population by removing financial barriers and providing access to inpatient, outpatient, primary and preventive health care services. Specific strategic objectives include:

Objective 1 Reduce the number of uninsured children

Objective 2 Increasing access to care

Objective 3 Increasing the use of preventive care

Objective 4 Reach and enroll CHIP eligible children

Objective 5 Reach and enroll Medicaid eligible children

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

The following performance goals and measures will be utilized to measure the effectiveness of Oregon's identified strategic objectives for CHIP:

Performance Goals for Objective 1:
The percentage of total low-income uninsured children will be maintained at less than, or equal to 5% of all eligible children in OR.
CHIP Population Uninsured – the percentage of uninsured children, 18 and under will be maintained at less than, or equal to 5% of all CHIP eligible children in OR.

Performance Goals for Objective 2:
Achieve 88.7% of patients (adults and children) who thought they received appointments and care when they needed them. Goal based on Metrics and Scoring Committee, based on 75th percentile of national Medicaid performance; Adult = 84.8%, Child = 92.6%.

Performance Goals for Objective 3:
Reach 75.4% (the 90th percentile for Medicaid) for 6 or more well-child visits in the first 15 months of life.

Performance Goals for Objective 4:
Increase the enrollment of CHIP eligible children. Measure the change in point-in-time count all children enrolled in CHIP programs for the final month of the current review year compared to the previous review year.

Performance Goals for Objective 5:
Increase the enrollment of Medicaid eligible children. Measure the change in point-in-time count all children enrolled in Medicaid programs for the final month of the current review year compared to the previous review year.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))
The State assures to use reliable, independent data sources to assist in conducting an objective evaluation of all performance measures. At a minimum, evaluation will be conducted annually to determine progress in meeting objectives.

Data source for Performance Goals	
Performance Goals	**Data source**
1 Reduce the number of uninsured children	Survey data: Oregon Health Insurance Survey (OHIS)*
2 Increasing access to care	CAHPS survey data
3 Increasing the use of preventive care	Eligibility or enrollment data & administrative (claims) data
4 Reach and enroll CHIP eligible children	Eligibility or enrollment data
5 Reach and enroll Medicaid eligible children	Eligibility or enrollment data

*The Oregon Health Insurance Survey is fielded in odd-numbered years. OHA plans to field the OHIS again in early 2023.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- **9.3.7.1.** ☒ Immunizations
- **9.3.7.2.** ☒ Well childcare
- **9.3.7.3.** ☒ Adolescent well visits
- **9.3.7.4.** ☐ Satisfaction with care
- **9.3.7.5.** ☒ Mental health
- **9.3.7.6.** ☒ Dental care
- **9.3.7.7.** ☐ Other, list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section

2107(c)) (42CFR 457.120(a) and (b))

Policy guidance for the development of Oregon's response to Title XXI includes substantial public comment and participation. The Oregon Legislature established the Oregon Health Council as the body responsible for providing a forum for public debate on the policy framework for the state's CHIP program. The Health Council is the policy-recommending body for health planning in the state. It consists of nine public members appointed by the Governor. The Health Council held a public hearing on Oregon's response to CHIP on October 18, 1997 in Salem, Oregon. At this meeting, approximately 30 interested parties, including consumers and consumer advocates, providers, managed care plans, insurance carriers, and educators, delivered testimony. Besides this focused, three-hour public hearing, the Health Council also solicited public comment at its regular meetings. At each of the six Council meetings held September 1997 through January 1998, written and oral public comment about CHIP was provided and discussed. On January 15, 1998, there were four additional public hearings around the state; Portland and Eugene in the Willamette Valley, Medford in Southern Oregon, and Bend in Central Oregon. Approximately 70 additional parties presented testimony at these hearings. There were comments on general program policy issues. Program staff then summarized this public input and presented to a joint meeting of the Health Council Additional opportunities to receive public input around CHIP design and implementation have occurred and continue. A draft of the initial Title XXI State Plan document was circulated for comment internally to state agencies and externally to providers, consumer advocates, and to a broad array of other interested parties. When the original Title XXI State Plan was submitted to CMS, OHA submitted a notice for publication in Oregon's major newspapers. All interested Oregonians were notified on how to obtain a copy of this document and had timely opportunity to comment on CHIP

Oregon Health Decisions conducted a series of approximately 200 meetings around the state. "Health Decisions '98" continued ongoing efforts by Oregon Health Decisions to engage Oregonians at the grass-roots level in a democratic approach to developing health policy. A similar series of "town hall meetings" in 1990 informed the setting of health service priorities by the Health Services Commission, information upon which they developed the Prioritized List of Health Services. A subsequent set of focus groups in 1995 addressed questions designed to identify the most sensible "next steps" for the Oregon Health Plan following implementation of the Medicaid expansion with benefits based on those priorities. "Health Decisions '98" focused on issues of how we finance health care, who ultimately pays for it, and how we can build more equity into the financing of health care while improving access and quality. As in the past with the Oregon Health Plan, public input on

CHIP and more general health care policy questions is being used to inform debate, set policy, and develop concepts for program development and proposed legislation. Public comment is a continuing part of Oregon's design, implementation, and refinement of its CHIP program and other expansions of the Oregon Health Pl

9.9.1 Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))
The Division engages Tribal consultation prior to submission of state plan amendments, waiver requests, proposed demonstration waivers, and rule-making likely to have a cost or direct impact on Oregon Native Americans, Indian Health Programs, or Urban Indian Organizations. To the extent practical and permitted by law, the state consults with Tribal governments as early as possible in the consultation process. This policy applies to the Children's Health Insurance Program in the same manner in which it applies to Medicaid.

A representative from the Medicaid Division attends quarterly "770" meetings to discuss proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have a direct impact on American Indians and Tribal entities. Face-to-face consultation is the preferred method of communication and consultation prior to submission of documents to the Centers for Medicare and Medicaid Services. In the event a deadline is out of the control of the Division, the communication and consultation will be handled by mail distributed through the OHA Tribal Liaison to Tribal designees. A monthly written Division of Medical Assistance Program Update is also provided to the OHA Tribal Liaison, who forwards it to Tribal designees. This update includes the status of State Plan Amendments, waiver or demonstration project proposals or amendments, and rule filings.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).
Prior to an amendment being submitted, OHA coordinates with the Oregon Health Policy Committee and Tribal organizations, Medicaid Advisory Committee or Legislative Committees as appropriate. Oregon Administrative Rules are filed and at a minimum OHA gives a public notice 45 days prior to any changes or closure of the program.

9.9.3 Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

The Division has a Tribal consultation policy. For SPA's with no direct effect on tribes the Division notifies them of any upcoming SPA submission on items with no direct effect or for federal law changes with limited flexibility for implementation. Items with a direct effect on Tribes are discussed at the quarterly meeting with the Tribal organizations, HIS etc at a committee meeting call the "770 meeting". The policy has been developed with the Tribal leaders in this committee and outlines how direct effect is determined what the procedures are for communication and timelines for notifications. For this specific SPA discussion were held at the tribal "770" committee meeting held in Bend, Oregon May 6, 2010 as well as an electronic summary distributed to the tribal contacts on July 21, 2010.

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

See attached

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
  - Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
  - Include a separate budget line to indicate the cost of providing coverage to pregnant women.
  - States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
  - Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
  - Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
  - Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide

the following:

- Total 1-year cost of adding prenatal coverage
- Estimate of unborn children covered in year 1

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate	
Fee for Service	
Health Services Initiatives	
Cost of Proposed SPA changes	
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	
Administration Costs	
Personnel	
General administration	
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	
10% Administrative Cap	
Federal Share	
State Share	
Total Costs of Approved CHIP Plan	

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds:

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states

developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX:

(Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.
FCEP clients and applicants have a right to a timely, written, impartial external review through the administrative hearing process that complies with 42 CFR 457.1120.
The Grievance and Appeal process are promulgated into Oregon Administrative Rule 410-141-3880 thru 3915 These are included as Attachment A to this state plan and can also be accessed on our web at https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR 457.1120.
FCEP clients and applicants have a right to a timely, written, impartial external review through the administrative hearing process that complies with 42 CFR 457.1120.
The Grievance and Appeal process are promulgated into Oregon Administrative Rule 410-141-3880 thru 3915. These are included as Attachment A to this state plan and can also be accessed on our web at https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
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Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5-Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
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Region 10-Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term `child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.

22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term `targeted low-income child' means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
    (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

4. MEDICAID APPLICABLE INCOME LEVEL- The term `Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means an individual—‘‘(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; ‘‘(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and ‘‘(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term `child' means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term `creditable health coverage' has the meaning given the term `creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms `group health plan', `group health insurance coverage', and `health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term `low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term `preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms `State child health plan' and `plan' mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term `uninsured child' means a child that does not have creditable health coverage.

410-141-3875

MCE Grievances & Appeals: Definitions and General Requirements

(1) The following definitions apply for purposes of this rule and OAR 410-141-3835 through OAR 410-141-3915:

(a) "Appeal" means a review by an Managed Care Entities (MCE), pursuant to OAR 410-141-3890 of an adverse benefit determination;

(b) "Adverse Benefit Determination" means any of the following, consistent with 42 CFR § 438.400(b):

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(B) The reduction, suspension, or termination of a previously authorized service;

(C) A denial, in whole or in part, of a payment for a service. A payment denied solely because the claim does not meet the definition of a "clean claim" at CFR 447.45(b) is not an adverse benefit determination;

(D) The failure to provide services in a timely manner pursuant to OAR 410-141-3515;

(E) The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;

(F) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

(G) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

(c) "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. For the purpose of this rule, pharmacy claims processed at point-of-sale (POS) that are rejected or denied shall not be considered "clean claims" that may trigger an Notice of Adverse Benefit Determination (NOABD);

(d) "Contested Case Hearing" means a hearing before the Authority under the procedures of OAR 410-141-3900 and OAR 410-120-1860;

(e) “Continuing benefits” means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910;

(f) “Grievance” means a member's expression of dissatisfaction to the MCE or to the Authority about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. A Grievance also includes a member’s right to dispute an extension of time proposed by the MCE to make an authorization decision;

(g) “Member” for actions taken regarding grievances and appeals, “member” includes, as appropriate, the member, the member’s representative, and the representative of a deceased member’s estate. With respect to MCE notification requirements, a separate notice must be sent to each individual who falls within this definition;

(h) “Notice of Adverse Benefit Determination” means the notice must meet all requirements found at 42 CFR 438.400.

(2) MCEs shall establish and have an Authority approved process and written procedures for compliance with grievance and appeals requirements that shall include the following:

(a) Member rights to file a grievance at any time for any matter other than an adverse benefit determination;

(b) Member rights to appeal and request an MCE review of a notice of adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;

(c) Member rights to request a contested case hearing regarding an MCE notice of adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;

(d) An explanation of how MCEs shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes;

(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;

(A) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing;

(B) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;

(C) The MCE shall provide the member the member’s case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals; and

(D) Ensure documentation of appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3915 and is consistent with contractual requirements.

(3) The MCE shall provide information to members regarding the following:

(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;

(b) Member rights and responsibilities; and

(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR §§ 438.408 (a) and these rules.

(5) Upon receipt of a grievance or appeal, the MCE shall:

(a) Within (5) five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Consistent with confidentiality requirements, obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;

(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:

(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;

(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:

(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;

(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.

(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;

(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.

(7) MCEs shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501 and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

(8) The following pertains to the release of a member's information:

(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:

(A) Resolving the matter; or

(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.

(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.

(9) The MCE shall provide Members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:

(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;

(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(10) The MCE, its subcontractors, and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;

(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

(11) In all MCE administrative offices and in those physical, behavioral, and dental health offices where the MCE has delegated responsibilities for appeal, hearing request, or grievance involvement, the MCE shall have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) MCE appeal forms (OHP 3302; or approved facsimile);

(c) Hearing request form Request to Review a Health Care Decision (OHP 3302).

(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.

(13) The member may request continuation of benefits from their MCE for services that were discontinued. If the member qualifies for continuation of benefits the MCE must provide the services while the appeal or administrative hearing is pending pursuant to OAR 410-141-3910.

(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If the MCE delegates any other portion of the grievance and appeal process to a subcontractor, the MCE must, in addition to the general obligations established under OAR 410-141-3505, do the following:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 98-2023, amend filed 12/28/2023, effective 01/01/2024
DMAP 89-2022, amend filed 12/16/2022, effective 01/01/2023

DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 62-2020, amend filed 12/16/2020, effective 01/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3880
Grievances & Appeals: Grievance Process Requirements

(1) A member and, with the written consent of the member, a provider or an authorized representative may file a grievance at any time either orally or in writing, on behalf of a member. The grievance may be filed with the MCE or the Authority. If the grievance is filed with the Authority, it shall be promptly forwarded to the MCE.

(2) For standard resolution of a grievance, the MCE shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires. The MCE shall:

(a) Within five business days from the date of the MCEs receipt of the grievance, notify the member in their preferred language that a decision on the grievance has been made and what that decisions is; or

(b) Promptly, but in no event more than five business days after the date of the MCE's receipt of the grievance, notify the member in their preferred language that there shall be a delay in the MCE's decision of up to 30 days from the date on which the grievance was received by the MCE. The written notice shall specify why the additional time is necessary.

(3) The MCE shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.

(4) When informing members of the MCE's decision, the MCE:

(a) May provide its decision related to oral grievances orally but shall also, in call instances respond to oral grievances in writing. Both oral and written responses shall be made in the member's preferred language;

(b) Shall address each aspect of the grievance and explain the reason for the decision;

(c) Shall respond in writing to written grievances in the member's preferred language. In addition to written responses, the MCE may also respond orally in the member's preferred language; and

(d) Shall notify members who are dissatisfied with the disposition of a grievance that they may present their grievance to the Department of Human Services (Department) Client Services Unit or the Authority's Ombudsperson.

(5) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, the MCE shall review and report to the Authority, as outlined in the CCO contract, member complaints related to their race and ethnicity, gender identity, sexual orientation, socioeconomic status, country of origin, and disability status.

(6) If an MCE receives a grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one MCE to another MCE as defined in OAR 410-141-3850, the MCE shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685
History:
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3885
Grievances & Appeals: Notice of Action/Adverse Benefit Determination

(1) When a Managed Care Entity (MCE) has made an adverse benefit determination, the MCE shall give the requesting provider, the Member and the member's representative a written Notice of Adverse Benefit Determination (NOABD). The notice shall:

(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in plain language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;

(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule.

(2) The following are notice requirements for preservice denials:

(a) Meet the content notice requirements specified in 42 CFR § 438.404 and in the MCE contract, including the following information:

(A) MCE contact information and subcontractor contact information including name, address, and telephone number, if applicable, included in the ABD notice excluding any cover pages;

(B) Date of the notice;

(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in the MCE within the last ninety (90) days, the NOABD shall state PCP, PCD, BH provider assignment has not occurred;

(D) Member's name, date of birth, address, and OHP member ID number;

(E) Service requested and the adverse benefit determination the MCE intends to make, including whether the MCE is denying, (in whole or part) terminating, suspending, or reducing a service;

(F) Date service was requested by the provider or member;

(G) Name of the provider who requested the service;

(H) Effective date of the adverse benefit determination if different from the date of the notice;

(I) Diagnosis and procedure codes submitted with the authorization request including a description of all codes in plain language. For services that do not include a procedure code a description of the requested service;

(J) Whether the MCE considered other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services pursuant to OAR 410-141-3820 and 410-141-3830;

(K) Clear and thorough explanation of the specific reasons for the adverse benefit determination. If the service has been denied as the provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the MCE have been made to obtain the documentation from the provider;

(L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the NOABD;

(M) The Member, member representative or, the provider with the member's written consent as required under OAR 410-141-3890(1), may file a written or oral appeal of the MCE's adverse benefit determination with the MCE within sixty (60) days from the date of the NOABD, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;

(N) The Member, member representative or the provider with the member's written consent has the right to request a contested case hearing either orally or in writing with the Authority 120 days from the date of the MCE's Notice of Appeal Resolution or where the MCE failed to meet appeal timelines (standard appeal sixteen (16) days to review and resolve appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3890, expedited appeal 72 hours to review and resolve appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3895), and the procedures to exercise that right;

(O) The circumstances under which an appeal process or contested case hearing can be expedited and how the Member, member representative or the member's provider may request it. If the MCE denies a request for an expedited appeal, it shall be transferred to the standard appeal resolution timeframes;

(P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, that continued benefits can be requested by the Member, member's representative or the provider with the member's written consent orally or in writing, the timeframes to request that benefits be continued as described in OAR 410-141-3910 and the circumstances under which the member may be required to pay the cost of these services;

(Q) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any

processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination;

(R) Information on requesting help and who to contact;

(S) To support their appeal, the member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the appeal timelines; and

(T) Inclusion of the names of providers or clinics copied on the notice;

(b) Use an Authority approved NOABD notice form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the NOABD.

(3) The following are notice requirements for postservice denials:

(a) Meet the content notice requirements specified in 42 CFR § 438.404 and in the MCE contract, including the following information:

(A) MCE contact information including name, address, and telephone number and subcontractor contact information, if applicable, included in the NOABD excluding any cover pages;

(B) Date of the notice;

(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in the MCE within the last ninety (90) days, the NOABD shall state PCP, PCD, BH provider assignment has not occurred;

(D) Member's name, D.O.B, address, and OHP member ID number;

(E) Service previously provided in plain language and the adverse benefit determination the MCE made;

(F) Date the service was provided;

(G) Name of the provider who provided the service;

(H) Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice;

(I) Diagnosis and procedure codes submitted on the claim including a description of all codes in plain language. For services that do not include a procedure code a description of the service provided in plain language;

(J) Whether the MCE considered other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830. NOABD shall clearly indicate whether a medical review was performed and if not that the provider can resubmit claim with chart notes for review of comorbidity;

(K) Clear and thorough explanation of the specific reasons for the adverse benefit determination. If the service has been denied as the provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the MCE have been made to obtain the documentation from the provider;

(L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;

(M) The Member, member representative or, the provider with the member's written consent as required under OAR 410-141-3890(1), may file a written or oral appeal of the MCE's adverse benefit determination with the MCE within 60 days from the date of the NOABD, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;

(N) The Member, member representative or the provider with the member's written consent has the right to request a contested case hearing either orally or in writing with the Authority 120 days from the date of the MCE's Notice of Appeal Resolution or where the MCE failed to meet appeal timelines (standard appeal 16 days to review and resolve appeal from date of receipt with a possible fourteen (14) day extension 410-141-3890, expedited appeal seventy two (72) hours to review and resolve appeal from date of receipt with a possible 14 day extension 410-141-3895) and the procedures to exercise that right;

(O) An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the Member, member representative or the member's provider may request it, but that an expedited appeal and hearing shall not be granted for post-service denials as the service has already been provided;

(P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, that continued benefits can be requested by the member, member's representative or the provider with the member's written consent orally or in writing, the timeframes to request that benefits be continued as described in OAR 410-141-3910 and the circumstances under which the member may be required to pay the cost of these services;

(Q) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination; and

(R) A statement that the provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166);

(S) To support their appeal, the member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the appeal timelines;

(T) Information on requesting help and who to contact; and

(U) Inclusion of the names of providers or clinics copied on the notice.

(b) Use an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the NOABD.

(4) The MCE shall provide a copy of the following when an NOABD is issued:

(a) Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile;

(b) Non-Discrimination Policy.

(5) For requirements of NOABD that affect services previously authorized, the MCE shall mail the notice at least ten (10) days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.

(6) In 42 CFR §§ 431.213 and 431.214, exceptions related to advance notice include the following:

(a) The MCE may mail the notice no later than the date of adverse benefit determination if:

(A) The MCE has factual information confirming the death of the member;

(B) The MCE receives notice that the services requested by the member are no longer desired or the MCE is provided with information that requires termination or reduction in services:

(i) All notices sent to a member under this section shall be in writing, clearly indicate the member understands that the services previously requested shall be terminated or reduced as a result of the notice and signed by the member;

(ii) All notices sent by the MCE under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.

(C) The MCE may verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;

(D) The MCE is unaware of the member's location and the MCE receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;

(E) The MCE verifies another state, territory, or commonwealth accepted the member for Medicaid services; or

(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.

(b) The MCE must mail the notice five days before the adverse benefit determination when the MCE has:

(A) Facts indicating that an adverse benefit determination may be taken because of probable fraud on part of the member; and

(B) Verified those facts, whenever possible, through secondary resources.

(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.

(7) Within sixty (60) days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that the MCE's adverse benefit determination is upheld; or if the MCE fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider the MCE appeals process exhausted.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 98-2023, amend filed 12/28/2023, effective 01/01/2024
DMAP 89-2022, amend filed 12/16/2022, effective 01/01/2023
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3890
Grievances & Appeals: Appeal Process

(1) A member, member representative, or provider with the member's written consent, may file an oral or written appeal with the Managed Care Entity (MCE) to:

(a) Express disagreement with an adverse benefit determination; or

(b) Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative. If the member leaves a voice mail message with the MCE indicating that they wish to appeal a denial the MCE shall make reasonable efforts (multiple calls at different times of day) to reach the member by phone to get the details of the service they wish to appeal. The MCE shall document each attempt to reach the

member (date(s) and time(s)) by phone and make note of the date they establish contact with the member and are able to attain the appeal information needed to process the appeal.

(2) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.

(3) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal:

(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing;

(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.

(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:

(A) Make reasonable efforts (including as necessary multiple calls at different times of day) to give the member prompt oral notice of the delay;

(B) Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision;

(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(4) For expedited resolution of an appeal please see OAR 410-141-3895. A request for an expedited appeal for a service that has already been provided to the member (post-service) shall not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth above section (3) of this rule.

(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.

(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408 (a) regarding the standard resolution of appeals by the MCE:

(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date;

(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.

(7) Parties to the appeal include, as applicable:

(a) The member and their representative; or

(b) The legal representative of a deceased Member's estate.

(8) The MCE shall resolve each standard appeal in time period defined above in section (4) of this rule. The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.

(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MCE must take the following steps:

(a) notify the Member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;

(b) Enter the prior authorization into the system or adjust the encounter data claim representing the service.

(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those services in accordance with the Authority policy and regulations.

(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of adverse benefit determination, as specified in OAR 410-141-3885, in addition to:

(a) The date the member filed the appeal with the MCE;

(b) The results of the resolution process and the date the MCE completed the resolution;

(c) Effective date of the appeal decision; and

(d) For appeals not resolved wholly in favor of the member:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;

(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and

(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;

(E) Copies of the appropriate forms: Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(e) For appeals resolved partially or wholly in favor of the member an explanation that the member may now access those benefits that were denied and how to do so.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 98-2023, amend filed 12/28/2023, effective 01/01/2024
DMAP 89-2022, amend filed 12/16/2022, effective 01/01/2023
DMAP 60-2022, amend filed 06/24/2022, effective 07/01/2022
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3895
Grievances & Appeals: Expedited Appeal

(1) Each MCE shall establish and maintain an expedited review process for all oral and written appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-120-1860. Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative.

(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.

(3) A request for an expedited appeal for a service that has already been provided (post-service) to the member will not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth in 410-141-3890 (4).

(4) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:

(a) Inform the member of the limited time available for receipt of materials or documentation for the review;

(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request;

(c) Mail written confirmation of the resolution to the member within three days;

(d) Extend the timeframes by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.

(e) If the MCE extends the timeframes not at the request of the member, the MCE shall:

(A) Make reasonable efforts (including as necessary multiple calls at different times of day) to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(5) If the MCE provides an expedited appeal but denies the services or items requested in the expedited appeal, the MCE shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.

(6) If the MCE denies a request for expedited resolution on appeal, the MCE shall:

(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;

(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 60-2022, amend filed 06/24/2022, effective 07/01/2022
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3900
Grievances & Appeals: Contested Case Hearings

(1) A Managed Care Entity (MCE) shall have a system in place to ensure its members and providers have access to appeal for MCE's action by requesting a contested case hearing:

(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-

003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures;

(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;

(c) Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.

(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that the MCE adverse benefit determination is upheld, subject to the exception under section (3) of this rule, below:

(a) The member shall file a hearing request with the Authority using form OHP 3302 or any other Oregon Health Authority (Authority)-approved appeal or hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;

(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, the MCE shall submit the required documentation to the Authority's Hearings Unit within two (2) business days of the Authority's request;

(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with the MCE, and if the request does not satisfy section (3) below, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:

(A) Review the request immediately as an appeal of the MCE's notice of adverse benefit determination;

(B) Respond to the request for the appeal within 16 days and provide the member with a notice of appeal resolution.

(d) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:

(A) Date-stamp the hearing request with the date of receipt; and

(B) Submit the following required documentation to the Authority within two business days:

(i) A copy of the hearing request notice of adverse benefit determination, and notice of appeal resolution;

(ii) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.

(3) If, after a member properly files an appeal, the MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted the MCE's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify the MCE of the Authority's decision to allow the member access to a contested case hearing.

(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.

(5) The parties to a contested case hearing include, as applicable:

(a) The member and their representative; or

(b) The legal representative of a deceased Member's estate; and

(c) The MCE.

(6) The Authority shall refer the hearing request along with the notice of adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within ninety (90) days from the date the MCE receives the member's request for appeal. The ninety (90)day count does not include the days between the date the MCE issued a notice of appeal resolution and the date the member filed a contested case hearing request.

(8) For reversed hearing resolution services:

(a) For services not furnished while the appeal or hearing is pending. If the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MCE must take the following steps:

(A) notify the Member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;

(B) Enter the prior authorization into the system or adjust the encounter data claim representing the service.

(b) For services furnished while the appeal or hearing is pending. If the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those services in accordance with the Authority policy and regulations.

(c) Any party to the hearing can file written exceptions or present argument to the Proposed and Final Order within ten working days after the date the Proposed Order is issued by the ALJ (see OAR 410-120-1860). If written exceptions are filed the Order does not become a Final Order on the 11th work day and the services shall not be provided until the Final Order is issued by OHA. Once a Final Order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of the MCE receiving the Final Order.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685
History:
DMAP 98-2023, amend filed 12/28/2023, effective 01/01/2024
DMAP 60-2022, amend filed 06/24/2022, effective 07/01/2022
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3905
Grievances & Appeals: Expedited Contested Case Hearings

(1) An MCE shall have a system in place to ensure its members and providers have access to expedited review for MCE's action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.

(2) A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.

(3) A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.

(4) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with the MCE, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.

(5) Expedited hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(6) The MCE shall submit relevant documentation to the Authority within two working days. The Authority shall decide within two working days from the date of receiving the relevant documentation whether the member is entitled to an expedited contested case hearing.

(7) If the Authority denies a request for an expedited contested case hearing, the Authority shall:

(a) Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and

(b) Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.

(8) If a member requests an expedited hearing, the Authority shall request documentation from the MCE, and the MCE shall submit relevant documentation including clinical documentation to the Authority within two working days.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3910
Grievances & Appeals: Continuation of Benefits

(1) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) A member can request continuation of benefits by phone, letter, fax or by using the Review of Health Care Decision form and check the box requesting continuing benefits by:

(A) The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;

(c) The Managed Care Entity (MCE) must continue the member's benefits if all of the following occur:

(A) The appeal involves the termination, suspension, or reduction of previously authorized services;

(B) The services were ordered by an authorized provider;

(C) The period covered by the original authorization has not expired; and

(D) The member timely files for continuation of benefits.

(d) If, at the member's request, the MCE continues or reinstates benefits while the appeal or hearing is pending, the benefits must be continued until one of the following occurs:

(A) The member fails to request a hearing and continuation of benefits within 10 calendar days after the date of the notice of appeal resolution;

(B) The member withdraws the appeal or request for hearing;

(C) A final order resolves the hearing.

(e) Member responsibility for services furnished while the appeal or hearing is pending. If the final resolution of the appeal or hearing is adverse to the member, that is, upholds the MCE's adverse benefit determination, the MCE may recover the cost of services furnished to the member while the appeal and hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

(2) For reversed appeal and hearing resolution services:

(a) Benefits not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal/hearing was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MCE must take the following steps:

(A) notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;

(B) Enter the prior authorization into the system or adjust the encounter data claim representing the service.

(b) Benefits furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the Authority shall pay for those services in accordance with the Authority policy and regulations.

Statutory/Other Authority: ORS 413.032, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685
History:
DMAP 98-2023, amend filed 12/28/2023, effective 01/01/2024
DMAP 62-2020, amend filed 12/16/2020, effective 01/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3915
Grievances & Appeals: System Recordkeeping

(1) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.

(2) Consistent with record retention requirements in OAR 410-141-3520, MCE's must maintain yearly logs of all appeals and grievances for 10 years, which must include information about the reasons for each grievance or appeal, as well as the resolution and supporting reasoning.

(3) The MCE must review the log monthly for completeness, accuracy, and compliance with required procedures.

(4) MCE's shall submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under the MCE contract.

(5) The Grievance System Report and Grievance and Appeals Log shall be forwarded to the MCE's Quality Improvement committee to comply with the Quality Improvement standards as follows:

(a) Review of completeness, accuracy, and timeliness of documentation;

(b) Compliance with written procedures for receipt, disposition, and documentation; and

(c) Compliance with applicable OHP rules.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

CHIP Eligibility

State Name: Oregon

OMB Control Number: 0938-1148

Transmittal Number: OR - 24 - 0140

Eligibility for Medicaid Expansion Program CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

Add	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	Remove
Add	0	6	133	300	Remove
Add	6	19	100	300	Remove

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

CHIP Eligibility

State Name: Oregon

OMB Control Number: 0938-1148

Transmittal Number: OR - 24 - 0140

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2107(e)(1)(K) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period

Mandatory Continuous Eligibility for Children

The CHIP Agency must provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, for a 12-month continuous eligibility period.

☐ Consistent with section 2107(e)(1)(K) of the SSA, the state assures that continuous eligibility is provided to its targeted low-income children for a duration of 12 months, regardless of any changes in circumstances, unless:

- ■ The child attains age 19.
- ■ The child or child's representative requests voluntary disenrollment.
- ■ The child is no longer a resident of the state.
- ■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- ■ The child dies.
- ■ The child becomes eligible for Medicaid.

The state elects to provide coverage to the from-conception-to-end-of-pregnancy (FCEP) population (otherwise known as the "unborn"). Yes

☒ The state assures continuous eligibility for the FCEP population is provided in the same manner as continuous eligibility for other targeted low-income children, except for the duration of the continuous eligibility period.

The duration of continuous eligibility for the FCEP population depends on whether a state enrolls the birthing parent into Medicaid for coverage of labor and delivery or pays for the delivery under CHIP. The state conducts at least one of the following actions upon birth of the child:

CHIP pays for labor and delivery and the state screens the child for potential eligibility for Medicaid. Yes

CHIP Eligibility

Emergency Medicaid pays for labor and delivery and the state deems the newborn eligible for Medicaid and ends the continuous eligibility period in CHIP.	No

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