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Oregon CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Oregon

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

Oregon Health Plan (OHP)

Who should we contact if we have any questions about your report?

4. Contact name:

Jesse Anderson

5. Job title:

State Plan Manager

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8. Phone number:

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PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☑ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All populations can be enrolled in a MCO/CCO but certain members, such as American Indians/Alaska Natives must opt into a MCO whereas other population groups are automatically enrolled. Some members are served via FFS due to their medical conditions, access or continuity of care or are part of the conception to birth population which are FFS only. We also have an Indian Managed care Entity through the PCCM program.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [x] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All populations can be enrolled in a MCO/CCO but certain members, such as American Indians/Alaska Natives must opt into a MCO whereas other population groups are automatically enrolled. Some members are served via FFS due to their medical conditions, access or continuity of care or are part of the conception to birth population which are FFS only. We also have an Indian Managed care Entity through the PCCM program.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ○ No
- ◉ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ○ No
- ◉ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ○ No
- ◉ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ○ Yes
- ○ No
- ◉ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ○ No
- ◉ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ○ No
- ◉ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ○ No
- ◉ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	70,101	74,398	6.13%
Separate CHIP	146,840	177,013	20.548%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	18,000	3,000	2.1%	0.3%
2016	15,000	3,000	1.7%	0.3%
2017	18,000	3,000	2%	0.3%
2018	17,000	3,000	1.9%	0.4%
2019	16,000	4,000	1.8%	0.4%
2020	Not Available	Not Available	Not Available	Not Available
2021	13,000	3,000	1.5%	0.3%

Percent change between 2019 and 2021
-16.67%

1. What are some reasons why the number and/or percent of uninsured children has changed?

Oregon made a policy decision to treat CHIP enrollment the same as we do Medicaid during the COVID PHE period. This resulted in keeping people enrolled that may have been determined to be not eligible. This, like the Medicaid MOE results in increases in enrollment in both programs.

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ○ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ◉ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

- ◉ Yes

  2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

  > Yes, these efforts have been successful. We've measured success on enrollment gains by county and race/ethnicity (enrollment for a number of sub-populations has increased at a much higher rate than the overall population or the children who have been identified as white/Caucasian). We also gauge our success based on feedback from community partners from these specific communities

- ○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

The Community Partner Outreach Program succeeded by coupling expansion of eligibility and simplified enrollment procedures with aggressive grassroots marketing and outreach initiatives. First, the community partner program awarded grants, ranging from $25,000 to $200,000 to community-based organizations to conduct outreach and provide assistance to families in applying for coverage. The CPOP also invites other types of organizations to be part of its robust community-based network. Healthcare providers can become outreach sites and receive training certifying them to provide application assistance. Additionally, other organizations signed up to enter in Volunteer agreements with the Oregon Health Authority to provide application assistance, following the same training and certification process to provide application assistance on a voluntary basis. Moreover, other types of community-based organizations can simply help spread the word about Healthy Kids/OHP for kids and medical coverage by referring families to the various application assistance sites. This community-based approach helped the CPOP create a strong and diverse network of partners in every county in the state, spanning from schools to health care centers to community action agencies. With a robust network of partners operating on the ground like field staff, the CPOP was also able to greatly expand its reach. Since June 2009, partners have distributed materials (fliers, newsletters, brochures) in all 36 counties. Partners sent more than 500,000 back-to-school fliers home in kids' backpacks in all 197 Oregon school districts. More than 75% of those fliers included contact information for a local partner to assist families with the application. During the back-to-school drive in 2014, the outreach grantees collaborated with more than 1,000 schools in 29 counties, building relationships with the staff and creating referral networks for uninsured families. All our partners play a significant role in reaching people across the state and providing them not only with information about affordable, accessible coverage and care but also on how to maintain health coverage beyond the initial 12-month enrollment. However, these relationships were not cultivated overnight. It took time to build networks in communities and to coordinate these efforts. We credit three essential strategies to their plan, which include: •Building an effective education, outreach and enrollment infrastructure •Using multiple channels and vehicles to reach the

uninsured •Providing comprehensive technical assistance to outreach and enrollment "partners." The Community Partner Outreach Program nurtured and built local partnerships across the state to ensure partners were engaged; allowing for families to have consistent statewide messages about the program reinforced by trusted and familiar sources in their schools, their health centers, through their employers, or local nonprofit organizations. As a result, enrollment numbers increased across every demographic throughout every county in the state. Today, most counties have at least one entity available to provide application assistance and answer questions about the medical coverage offered through the Healthy Kids Program/OHP for kids.

4. Is there anything else you'd like to add about your outreach efforts?

The OHA Community Partner Program continues to lead OHA's community outreach, engagement, and education efforts. Especially, during the current pandemic it continues to show the effectiveness of our approach to community work of working and contracting with Community Partner Organizations across the state. Our work serving minorities, migrant seasonal farmworkers, and rural areas has been highlighted at the national level, due to its effectiveness in identifying needs and connecting community members with resources. Additionally, our program has expanded efforts to serve three newer populations in our state, the Afghan refugee, COFA, and indigenous Mesoamerican communities.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

_____ %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- [x] Yes

    1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

    %

    1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

    %

- [ ] No

- [ ] N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- [ ] Yes

- [x] No

3. Do you send renewal reminder notices to families?

- [x] Yes

    3a. How many notices do you send to families before disenrolling a child from the program?

    2

    3b. How many days before the end of the eligibility period did you send reminder notices to families?

    N/A

- [ ] No

4. What else have you done to simplify the eligibility renewal process for families?

working on an integrated eligibility system

5. Which retention strategies have you found to be most effective?

haven't evaluated it

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

have not measured

7. Is there anything else you'd like to add that wasn't already covered?

No

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

101713

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

21

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

101692

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

5. Did you have any limitations in collecting these data?

Under the temporary public health emergency rules, Oregon is not disenrolling children from CHIP after ineligibility is established. Disenrollment only takes place upon moving out of state, death, or upon request from the consumer.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	0.2%
Denied for eligibility reasons	99.98%
Denials for other reasons	

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

135330

2. Of the eligible children, how many were then screened for redetermination?

123880

3. How many children were retained in CHIP after redetermination?

123880

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

0

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

Under the temporary public health emergency rules, Oregon is not disenrolling children from CHIP after ineligibility is established. Disenrollment only takes place upon moving out of state, death, or upon request from the consumer.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	100%
Children disenrolled after redetermination	0%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

Oregon does not track children's Medicaid renewals separately from the total Medicaid renewal counts.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
354	6194	6068	2718

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
264	4408	4365	2003

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
15	156	121	59

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
15	155	119	59

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
75	1630	1582	656

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
66	1537	1520	623

9. Is there anything else you'd like to add about your data?

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
5683	5698	6992	3198

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
5421	4561	5747	2658

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
20	119	138	65

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
17	115	133	58

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
242	1018	1107	475

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
102	871	940	392

9. Is there anything else you'd like to add about your data?

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- ○ Yes
- ◉ No

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- ◉ Yes
- ○ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- ◉ Yes
- ○ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

Oregon has a robust audit function that consists of 12 Governmental Auditors 2 (three CPCs; four CPMAs; one CDC; one CRC; one CPC-I); one Medical Review Coordinator (RN), one Governmental Auditor 3 (CPA), two Research Analysts 4 (one CPC), two Research 3,one Operations and Policy Analyst 4 (RN), one CFE, and one Administrative Assistant. OPI Management consists of one PEM D manager over the SURS/SIU/Policy Unit (Masters level statistician), one PEM D manager over the Program Integrity Audit Unit (Masters level in leadership and organizational communication), and one Administrator G (Masters level in Behavioral Health counseling). Auditors perform onsite and desk audits of simple and complex issues with different provider types, MCE network providers, and managed care entities, known as Coordinated Care Organizations (CCO) in Oregon. Research analysts use a SAS Visual Investigator analytic platform to perform data analysis/utilization reviews in determining potential audit leads. Potential leads are screened with the objective of forming an audit/no audit decision. When audits are selected to be opened, the Program Integrity Audit Unit (PIAU) utilizes statistically valid random sampling to review a provider's entire claims population for a defined period. For a small portion of audits, the PIAU will review all actual claims. Overpayments are assessed using extrapolation or actual billed amounts when material violations of rules for reimbursement are found. The researcher performs algorithms on paid claims as another strategy for monitoring claims to detect fraud, waste, and abuse. Oregon has a memorandum of understanding with the Oregon Department of Justice Medicaid Fraud Control Unit (MFCU). The State remains responsible for conducting preliminary investigations on potential fraud and abuse. Below are examples of cases which may be referred to the MFCU: a. Cases in which sampled or audited services are not supported by documentation and there is a suspicion of fraudulent intent. b. Cases in which sampled or audited services are billed at a higher-level procedure code than is documented in violation of state and/ or federal rules and/ or regulations and there is suspicion of fraudulent intent. c. Verified cases where the provider billed Oregon Medicaid at a higher rate than non-Medicaid recipients or other insurance programs. d. Verified cases where the provider purposely altered or destroyed documentation to collect Medicaid payments not otherwise due. e. Cases that are found to have characteristics which appear to Oregon Medicaid to indicate a potential for fraud. f. Cases where Oregon Medicaid has revoked a provider's billing number based on violation of an

administrative rule.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  The managed care entities, CCO's, have extensive program integrity deliverables in the contract with the state. See attached 2022 CCO Contract Template, Exhibit B-Statement of Work--Part 9 Program Integrity of the CCO contract.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

429

7. How many cases have been found in favor of the beneficiary in FFY 2022?

<11

8. How many cases related to provider credentialing were investigated in FFY 2022?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

10. How many cases related to provider billing were investigated in FFY 2022?

457

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

20

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

371

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

<11

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ◉ Yes

  15a. How do you provide oversight of the contractors?

  > Along with our own program integrity staff and audit units Oregon has a Recovery Audit Contractor (HMS), under contract and there is a contract administrator and operations staff providing oversight. CMS contracts with the UPIC and provides oversight to that contract. The CCO contracts have oversight by the Health Systems Division within OHA, as well as the Office for Program Integrity for oversight of the program integrity deliverables.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- ○ Yes
- ◉ No

17. Is there anything else you'd like to add that wasn't already covered?

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
483	4976	12860	19126	24434	17911

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
420	3548	6977	11030	12540	7250

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	1150	5784	10567	11902	6352

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
12	221	1849	4697	4504	3151

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

2981

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - (●) Yes
  - ( ) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Oregon Poison Control Center

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Children 19 and under

4. How many children do you estimate are being served by the HSI program?

17779

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Cost savings from effective management of patients at home without referral to a health care facility.

7. What outcomes have you found when measuring the impact?

• Last year 17,779 (54.3%) exposure calls involved children 0-19 years old. • 14,400 exposure cases were calls from their homes. • Of those calls, we managed 13,217 (92%) at home; they did not need to go to the emergency department or see any healthcare provider. • Home management involved careful monitoring and follow-up by the Poison Center Health Care Providers. • According to USA Today* the average emergency room visit costs $1,389. The Poison Center saved medical costs of at least $18,358,413 if all our home-managed patients went to the emergency department. *https://www.usatoday.com/story/news/health/2019/06/04/hospital-billing-code-changes-help-explain-176-surge-er-costs/1336321001/

8. Is there anything else you'd like to add about this HSI program?

The Oregon Poison Center does not collect insurance information from our patients. We serve all Oregonians. The poison center is available and utilized consistently by this population each year regardless of insurance coverage. Children through age 19 represent approximately 54% of the patients we serve in Oregon.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Reduce the number of uninsured children

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Estimated population of uninsured children (18 and under) in Oregon.

4. Numerator (total number)

15650

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Estimated population of children (18 and under) in Oregon.

6. Denominator (total number)

931759

Computed: 1.68%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

09 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, the uninsured rate among children remains low at 1.7%, which is under the 5% goal

10. What are you doing to continually make progress towards your goal?

Continue to leverage the Affordable Care Act Medicaid expansion and utilize Healthcare.Oregon.gov to help residents to navigate Medicaid/CHIP eligibility or premium subsidies.

11. Anything else you'd like to tell us about this goal?

Yes, and the goal will remain the same. The Oregon Health Insurance Survey is fielded in odd-numbered years. OHA plans to field the OHIS again in early 2023. 13. Optional: Attach any additional documents here. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Maximize access to care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

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%.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Those meeting top response categories for CAHPS Access to Care composite.

4. Numerator (total number)

4185

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Continuously enrolled in a Medicaid with no more than a 45 day break. Children in denominator needed a routine care appointment and/or emergency care.

6. Denominator (total number)

5129

Computed: 81.59%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

No, it has decreased from FFY2020 at 84.6% to FFY2021 at 81.6%. The decrease is anticipated given the continuing impact from the COVID-19 pandemic.

10. What are you doing to continually make progress towards your goal?

The measure was incentivized in the CCO quality measure program through CY2019 to improve access to care but discontinued starting 2020 per Metrics and Scoring Committee decision. OHA continued to monitor the CAHPS measure for access to care.

11. Anything else you'd like to tell us about this goal?

No

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase Well-care visits for young children.

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

Reach 75.4% (the 90th percentile for Medicaid) for 6 or more well-child visits in the first 15 months of life.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

Number of children in specified age range with six or more visits

4. Numerator (total number)

10363

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

Children who are 15 months old during the measurement year, and continuously enrolled from 31 days to 15 months of age.

6. Denominator (total number)

17517

Computed: 59.16%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

No, the rate decreased slightly from 60.5% in FFY2021 to 59.2% in FFY2022, which is anticipated due to the continuing impact from the COVID-19 pandemic.

10. What are you doing to continually make progress towards your goal?

Continue to utilize CCO care delivery system for access to preventive services and care coordination

11. Anything else you'd like to tell us about this goal?

No

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Reach and enroll CHIP eligible children

1. Briefly describe your goal as it relates to this objective.

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 FFY2022 compared to FFY2021.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Point-in-time count all children enrolled in CHIP programs for the final month of FFY2022 (September 2021)

4. Numerator (total number)

115710

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Point-in-time count all children enrolled in CHIP programs for the final month of FFY2021 (September 2020).

6. Denominator (total number)

92044

Computed: 125.71%

7. What is the date range of your data?

Start

mm/yyyy

09 / 2020

End

mm/yyyy

09 / 2021

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, CHIP enrollment increased by 26% from September 2020 to September 2021. However, the increase was largely due to the freeze of eligibility re-determination during the COVID-19 emergency.

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

No

12. Do you have any supporting documentation?
Optional

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Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Reach and enroll Medicaid eligible children

1. Briefly describe your goal as it relates to this objective.

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 FFY2022 compared to FFY2021.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Point-in-time count all children (age 0-18) enrolled in Medicaid programs for the final month of FFY2022 (September 2021).

4. Numerator (total number)

473742

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Point-in-time count all children (age 0-18) enrolled in Medicaid programs for the final month of FFY2021 (September 2020).

6. Denominator (total number)

445999

Computed: 106.22%

7. What is the date range of your data?

Start

mm/yyyy

09 / 2020

End

mm/yyyy

09 / 2021

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, the Medicaid children enrollment increased by 6% from September 2020 to September 2021. However, the increase was largely due to the freeze of eligibility re-determination during the COVID-19 emergency.

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

No

12. Do you have any supporting documentation?
Optional

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Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

No

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

No

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

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Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 477,936,537	**$** 525,692,512	**$** 567,306,627

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 73,574,018	**$** 80,672,755	**$** 87,056,856

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	477936537	525692512	567306627
Fee for Service	73574018	80672755	87056856
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	0	0	0
Total benefit costs	551510555	606365267	654363483

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 557,621	**$** 919,778	**$** 992,588

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 2,323,417	**$** 3,832,407	**$** 4,135,783

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 1,765,798	**$** 2,912,630	**$** 3,143,195

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 864,726	**$** 1,000,000	**$** 1,000,000

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 1,847,551	**$** 2,845,178	**$** 2,845,178

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 8,730,303	**$** 8,001,599	**$** 8,001,599

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	557621	919778	992588
General administration	2323417	3832407	4135783
Contractors and brokers	0	0	0
Claims processing	1765798	2912630	3143195
Outreach and marketing	864726	1000000	1000000
Health Services Initiatives (HSI)	1847551	2845178	2845178
Other administrative costs	8730303	8001599	8001599
Total administrative costs	16089416	19511592	20118343
10% administrative cap	61278950.56	67373918.56	72707053.67

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	567599971	625876859	674481826
eFMAP	72.15	72.22	72.15
Federal share	409523379.08	452008267.57	486638637.46
State share	158076591.92	173868591.43	187843188.54

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 162,043	**$** 149,115	**$** 148,817

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 246	**$** 294	**$** 318

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	246	294	318

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 16,612	**$** 13,919	**$** 13,919

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 369	**$** 483	**$** 521

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	369	483	521

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

2. Optional: Attach any additional documents here.

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

COVID continues to be a challenge both physically and financially. Staff shortages and increases hospitalizations have stressed the healthcare system however, the Governor's focus has been on coverage for all, especially children.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The same issues as last year, work force shortages due to COVID, weather relayed events that disproportionately impact BIPOC communities, Tribal communities and unhoused populations.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

Oregon continues to close the gap on uninsurance rates. The SSMA is committed to eliminating health inequities by 2030. FFS transformation has started to operate the FFS population more like our CCO managed care entities.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

Still moving toward moving from a separate CHIP program to be a Medicaid expansion program in 2023.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

6. Optional: Attach any additional documents here.

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