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

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

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

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

Populations Affected by OHP

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

Title XIX State Plan Populations

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

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

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

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

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

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

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

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

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

Demonstration Expansion Populations

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

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

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

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

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

Population 16: Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with income from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in premium assistance under FHIAP.

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

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

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

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

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

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

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

Title XIX Waiver Authority

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

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

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

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

To enable the State to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the State Plan to mandatory Medicaid populations, and to enable the State to limit the scope of services for optional and expansion populations. (Applies to populations 1 -11, 21 and the direct coverage portion of population 22, with the exception of Population 3 for children 0 up to 1 year of age.)

3. Eligibility Standards **Section 1902(a)(17)**
42 CFR 435.100 and
435.602-435.823

Until January 1, 2014, to enable the State to waive income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming restrictions, and to base eligibility on household family unit (rather than individual income). (Applies to Populations 1, 2, 3, 4, 9, 10, 11, 14, 17, 18 and 22).

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

Until January 1, 2014, to enable the State to apply streamlined eligibility rules for individuals. The 3-month retroactive coverage will not apply, and income eligibility will be based only on gross income. (Applies to Populations 1, 2, 3, 4, 9, 10, 11, 14, 17, 18 and 22.)

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

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

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

To allow the State to restrict coverage of services required to treat a condition identified during an EPSDT screening to the extent that the services are beyond the scope of the benefit package available to the individual. The State must arrange for, and make available, all services within the scope of the benefit package available to the individual that are required for treatment of conditions identified as part of an EPSDT screening. (Applies to all Populations above.)

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

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

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

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

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

Until January 1, 2014, to permit the State to implement a reservation list as a tool to manage enrollment in OHP-Standard and FHIAP. (Applies to Populations 10, 11, 14, 17, and 18.)

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

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

Title XXI Waiver Authority

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

1. Benefit Package Requirements **Section 2103**

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

Title XXI - Costs Not Otherwise Matchable (CNOM)

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

a. **Population 16:** Until January 1, 2014, uninsured children ages 0 through 5 with incomes from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with incomes from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in premium assistance under FHIAP.

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

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities:

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

Rules governing cost sharing under section 2103(e) of the Act shall not apply to Demonstration Populations 16 and 20 to the extent necessary to enable the State to subject beneficiaries to the cost sharing required under the private or ESI plan coverage that the individual has elected.

Title XIX - Costs Not Otherwise Matchable (CNOM)

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

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.

2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.

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

5. Until January 1, 2014, Expenditures for health care-related costs for Demonstration Populations 9, 10, 11, 14, 17, and 18.

6. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 54 and as described in Section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. This expenditure authority will not be renewed or extended after June 30, 2017.