

April 20, 2023

Dana Hittle
Medicaid Director
Oregon Health Authority
500 Summer Street NE, E35
Salem, OR 97301

Dear Ms. Hittle:

The Centers for Medicare & Medicaid Services (CMS) is approving Oregon's amendment to its section 1115(a) demonstration titled "Oregon Health Plan" (Project Number 11-W-00415/10). The state originally submitted this request as an amendment to the "Oregon Health Plan Substance Use Disorder 1115 Demonstration" (Project Number 11-W-00362/10). To better align the populations served in the demonstration with services requested, this amendment will be incorporated in the Oregon Health Plan demonstration and will be effective as of the date of this letter.

Approval of this amendment will enable beneficiaries ages 19 through 64 with incomes above 133 and up to and including 200 percent of the federal poverty level (FPL) to maintain Medicaid coverage following the expiration of the continuous enrollment provision in Families First Coronavirus Response Act (FFCRA) if the beneficiary is currently enrolled in Medicaid.

We have determined that this amendment is likely to assist in promoting the objectives of Medicaid as it will continue to provide access to Medicaid services to certain beneficiaries at risk of losing coverage and will provide coverage until transition into the state's Basic Health Program (BHP) or other state coverage option is available.

CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STC), and any supplemental attachments defining the nature, character, and extent of federal involvement in this demonstration project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable under the demonstration.

Request Not Being Approved at this Time

Oregon's amendment application also included a request to establish a new, permanent eligibility group for populations that are currently exempt or excluded from mandatory enrollment in a Coordinated Care Organizations (CCO) who would otherwise be eligible for enrollment in a

BHP regardless of current Medicaid status. CMS will continue discussions with the state, and is not approving this portion of the request at this time.

Budget Neutrality

This demonstration amendment is projected to be budget neutral to the federal government. As described in the SMDL #18-011, all expenditures incurred under this amendment will be treated as pass-through, or “hypothetical.” In other words, the state may claim federal financial participation (FFP) for the services allowable under the demonstration amendment, but it may not accrue “savings” in the event that spending is less than projected/allowable. However, FFP provided under section 1115(a)(2) in any excess spending/overages must be returned to CMS.

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be “budget neutral,” meaning the federal costs of the state’s Medicaid program with the demonstration cannot exceed what the federal government’s Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” (WOW) costs).

The state projects that the total aggregate expenditures will be budget neutral and that approximately 55,000 beneficiaries will be impacted by the demonstration amendment.

Monitoring and Evaluation

Consistent with CMS requirements for section 1115 demonstrations, and as described in the OHP demonstration STCs, the state is required to conduct systematic monitoring and robust evaluation of the demonstration’s various programs. These activities now must also appropriately accommodate the population covered through this amendment after the end of the FFCRA continuous enrollment requirement. Based on program participation criteria, all relevant monitoring and evaluation STCs apply for the amendment population, with an overarching goal of assessing the effects of the demonstration on expanding coverage and access to care and improving health outcomes overall as well as among key subpopulations of Medicaid beneficiaries.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of Social Security Act (the Act) direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an

impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act specifies that comment periods should be “sufficient to ensure a meaningful level of public input,” but the statute imposed no additional requirement on the states or the Secretary to provide an individualized response to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide individualized written responses to public comments.

CMS held its federal comment period from November 30, 2022 through, December 29, 2022, and received five comments. All five comments were in support of the amendment, though one expressed opposition to the state establishing a BHP, claiming that its establishment would be detrimental to exchange premiums, provider rates and Marketplace enrollment. The impact on the Marketplace of maintaining Medicaid coverage for the population covered in this demo is expected to be minimal. CMS looks forward to having continued discussions with the state about how to mitigate impacts to its Marketplace if the state establishes a full BHP.

After carefully reviewing the public comments submitted during the federal comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid. The award is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Felicia Pailen. Ms. Pailen is available to answer any questions concerning implementation of the state’s section 1115(a) demonstration amendment and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Felicia.Pailen@cms.hhs.gov

We look forward to our continued partnership on the Oregon Health Plan demonstration. If you have any questions regarding this approval, please contact Ms. Mehreen H. Rashid, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



Daniel Tsai
Deputy Administrator and Director

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Enclosures

cc: Nikki Lemmon, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00415/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers shall enable Oregon to implement the Oregon Health Plan (OHP) Demonstration beginning on October 1, 2022 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented in accordance with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

All requirements of the Medicaid program and the Children's Health Insurance Program (CHIP) expressed in law, regulation, and policy statement, not expressly waived in this list or identified as not applicable in the accompanying expenditure authority and/or the approved STCs, shall apply to the demonstration from the approval date, through September 30, 2027, unless otherwise specified.

Title XIX and XXI Waiver Authority/Not Applicable

Statewideness/Uniformity

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

To enable the state to provide benefits through contracts with managed care plans that operate only in certain geographical areas of the state. (Applies to all Medicaid state plan and CHIP populations listed in Attachment C.)

To enable the state to cover Health-Related Social Needs (HRSN) services on a geographically limited, county-by-county basis during the phase in process through December 31, 2024.

Amount, Duration, and Scope of Services

**Section 1902(a)(10)(A)
1902(a)(10)(B)
1902(a)(17)
42 CFR 440.230-250**

To enable the state to offer different benefits for individuals whose eligibility is determined based on modified adjusted gross income (MAGI) (other than children under age 21, Youth with Special Health Care Needs, pregnant individuals, and individuals enrolled in the Alternative Benefits Plan) which are consistent with a Prioritized List of Health Services, as defined in STC 4.2.d, subject to certain exceptions for protected benefits. This authority will expire January 1, 2027.

Amount, Duration, and Scope of Services and Comparability**Section 1902(a)(10)(B)
1902(a)(17)**

To the extent necessary to allow the state to offer the HRSN services as described in STC 9.

To the extent necessary to enable the state to provide HRSN services based on service delivery systems that are not otherwise available to all beneficiaries in the same eligibility group during the phase in process through December 31, 2024.

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

To allow the state to restrict coverage for treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a Prioritized List of Health Services, as defined in STC 4.2.d, through December 31, 2022. (Applies to all Medicaid state plan populations, except population 23.)

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 plans (and other insurers) in a manner not authorized by section 1932 of the Act because beneficiaries may not have a choice of managed care plans. This does not authorize restricting freedom of choice of family planning providers. (Applies to all Medicaid state plan and CHIP populations listed in Attachment C.)

Managed Care Plan Enrollment**Section 1902(a)(4)
as implemented in
42 CFR 438.56(c) and 438.52**

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. Medicaid and CHIP 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 and CHIP populations listed in Attachment C.)

To the extent necessary to permit the state to enter into contracts with a single prepaid ambulatory health plan (PAHP) for the delivery of dental services, including preventive care, restoration of fillings, and repair of dentures, through Dental Care Organization in accordance with 42 CFR 438.52, through December 31, 2022. (Applies to all fee-for-service Medicaid state plan populations not enrolled in a CCO listed in Attachment C.)

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00415/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

Title XIX – Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) 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 care plans 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 a Coordinated Care Organization (CCO).
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 primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority that were restricted or eliminated from coverage effective January 1, 2010 for non-pregnant adults enrolled in OHP.
5. **Designated State Health Programs (DSHP).** Expenditures for designated programs, described in these STCs, which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. These expenditures are specifically contingent on compliance with STC 10, as well as all other applicable STCs.
6. **Health-Related Social Needs (HRSN) Services.** Expenditures for approved evidence-based health-related social needs services not otherwise eligible for Medicaid payment furnished to

individuals who meet the qualifying criteria as described in STC 9. These expenditures are contingent on compliance with STC 10, as well as all other applicable STCs.

7. **Health-Related Social Needs Services Infrastructure.** Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized as part of the approved HRSN infrastructure activities in STC 9. These expenditures are contingent on compliance with STC 10, as well as all other applicable STCs.
8. **Continuous Eligibility.** Expenditures for continued benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.5.c.
9. **Youth with Special Health Care Needs (YSHCN).** Expenditures for services for individuals ages 19 through 26, with income up to 300 percent FPL, and with special health care needs as defined in STC 4.6.
10. **MAGI Expanded Adult Program.**
Expenditures for Medicaid beneficiaries who are age 19 through 64, with household income from 133 up to and including 200 percent of the FPL at the time of their redetermination following the end of continuous enrollment and any subsequent redetermination, and who would otherwise lose eligibility for Medicaid due to income. The expenditure authority is effective until the state has established its Basic Health Program or other state coverage option is available. Authority for these expenditures is effective on the date of the approval letter for the MAGI Expanded Adult Program amendment to this demonstration. New applicants in this income range are not eligible for this expenditure authority.

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), state expenditures described below, shall, for the period of this demonstration, October 1, 2022 through September 30, 2027, 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 Title XXI will be applicable to such expenditures for demonstration population 4 as described in Attachment C, except those specified in STC 4.5 as not applicable to these expenditure authorities.

11. **Continuous Eligibility.** Expenditures for continued benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.5.c.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00415/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

1. PREFACE

The following are the special terms and conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program section 1115(a) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to these STCs are the Oregon Health Authority (state) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The STCs are effective as of October 1, 2022 through September 30, 2027, unless otherwise specified.

The STCs have been arranged into the following areas:

1. Preface
2. Program Description, Objectives, Historical Context
3. General Program Requirements
4. Eligibility and Enrollment
5. Delivery System
6. Capitation Rates and Performance Measures
7. Measurement of Quality of Care and Access to Care Improvement
8. Designated State Health Programs
9. Health-Related Social Needs
10. Provider Payment Rate Increase Requirement
11. General Reporting Requirements
12. General Financial Requirements
13. Monitoring Budget Neutrality for the Demonstration
14. Monitoring Allotment Neutrality
15. Evaluation of the Demonstration
16. Schedule of the State Deliverables for the Demonstration Period

Additional attachments and appendices have been included to provide supplementary information and guidance for specific STCs.

Attachment A. Developing the Evaluation Design

Attachment B. Preparing the Interim and Summative Evaluation Reports

Attachment C. Summary Chart of Demonstration Populations
Attachment D. Model Tribal Engagement and Collaboration Protocol (reserved)
Attachment E. Coordinated Care Organizations Services Inventory (reserved)
Attachment F. Approved DSHP List (reserved)
Attachment G. DSHP Claiming Protocol (reserved)
Attachment H. DSHP Sustainability Plan (reserved)
Attachment J. Protocols for HRSN Infrastructure and HRSN Services (reserved)
Attachment K. Oregon Provider Payment Rate Increase Assessment – Attestation Table (reserved)
Attachment L. New Initiatives Implementation Plan (reserved)
Attachment M. Monitoring Protocol (reserved)
Attachment N. Prioritized List Phase-Out Plan (reserved)
Attachment O. Evaluation Design (reserved)
Appendix. Description of State Operations

2. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases in February 1994. Phase I of the Medicaid demonstration Project started on February 1, 1994. Originally, the demonstration affected Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II added the aged, blind, disabled, and children in state custody/foster care.

Objectives

Under the demonstration, Oregon strives to promote the objectives of title XIX by:

- Providing a basic benefit package;
- Ensuring broad participation by health care providers;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Structuring benefits (what is covered) using a Prioritized List of Health Services;
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
 - Improving the individual experience of care;
 - Improving the health of populations; and
 - Reducing the per capita costs of care for populations through such improvements.
- Expanding the scope of services available through IHS and tribal health facilities, stabilizing the IHS and tribal health system and improving health outcomes for Medicaid and low-income populations utilizing these facilities.

Historical Context: Demonstration Extensions and Amendments

CMS initially approved the Oregon Health Plan (OHP) section 1115 demonstration for a five-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs by using managed care and a Prioritized List of Health Services. This list is updated every two (2) years, whereby services are added, deleted, or moved to a different ranking within the list. CMS approved Oregon's 2002 application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provided premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

In 2007, CMS revised the structure of the populations within the demonstration to reflect updated law and CMS policy. In 2009, CMS approved an amendment to the demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children from birth through age 18 in the state with family incomes from 0 up to and including 300 percent of FPL. In addition, the CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a "reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

In 2012, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and authorized expenditures on certain Designated State Health Programs (DSHP). In October 2013, CMS approved an amendment to add tribal health programs supplemental primary care payments to the demonstration. The amendment allows the state to make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority.

In December 2013, CMS approved amendments to align eligibility, populations, and benefits in the demonstration with provisions in the Affordable Care Act and approved a one-year extension of uncompensated care payments to IHS or tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority.

In January 2017, CMS approved an extension to continue and enhance Oregon's Health System Transformation. The extension of OHP sought to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon utilized community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement to improve the coordinated care model.

In February 2022, the state submitted an application to extend the demonstration, continuing foundational elements of OHP, while incorporating significant changes to focus on addressing health inequities within the state. Oregon's requests aim to make meaningful improvements to

health outcomes across the state by improving access, addressing health equity, strengthening health care systems, and addressing Health-Related Social Needs (HRSN) that contribute to poor health outcomes of Medicaid beneficiaries within the state. Approval of this request will allow the state to: provide continuous eligibility for children from birth through age five, as well as twenty-four month continuous eligibility for those ages six and above; expand coverage to Youth with Special Health Care Needs ages nineteen through twenty-six; cover new services to address a defined set of evidence-based health-related social needs; and authorize DSHP funding to support state funding of these initiatives.

In April 2023, CMS approved an amendment to this demonstration which continues enrollment for those beneficiaries with incomes from 133 up to and including 200 percent of the federal poverty level (FPL) at the time of their redetermination following the end of continuous enrollment condition under section 6008(b)(3) of the Families First Coronavirus Response Act (as amended) and any subsequent redetermination, and who would otherwise lose eligibility for Medicaid due to income. Applicants ages 19 through 64 who apply for Medicaid on or after the date of the approval letter who have household incomes from 133 up to and including 200 percent of the FPL at the time they submit their Medicaid applications are not eligible for the MAGI expanded Adult Program. The objective is to reduce the loss of health care coverage as a result of the end of continuous enrollment provision of the Families First Coronavirus Response Act (FFCRA).

3. GENERAL PROGRAM REQUIREMENTS

- 3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state thirty (30) business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7) as a result of the change in FFP.
- b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or the day such legislation was required to be in effect under federal law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to demonstration eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health and Human Services (HHS) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than one hundred twenty (120) calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny (or delay approval of) a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public

feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

- b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
- c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment, which isolates (by eligibility group) the impact of the amendment;
- d. An up-to-date CHIP allotment worksheet, if necessary;
- e. Updates provided by the state to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring, and measurement of the provisions.

3.8. Extension of the Demonstration. If the state intends to request an extension of the demonstration, it must apply to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 CFR 431.412(c). If the state does not intend to request an extension of a demonstration beyond the period authorized in these STCs, it must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration, in whole or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state’s response to the comment and how the state incorporated the received comment into the revised phase-out plan.
- b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary’s appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the

affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

- c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) days after CMS approval of the transition and phase-out plan.
- d. **Transition and Phase-out Procedures.** The state must comply with all applicable notice requirements found in 42 CFR part 431 subpart E, including sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e. **Exemption from Partial Notice Procedures 42 CFR 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. **Federal Financial Participation.** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with termination of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Expiring Demonstration Authority.** With the exception of changes to EPSDT and the Prioritized List of Health Services outlined in STC 4.2.c and 11.8, for demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected

beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination as discussed in the October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.
- d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and

enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

- 3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to applying to extend the demonstration. For applications to amend the demonstration, the state must comply with state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid state plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

- a. **Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations.** In states with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 State Medicaid Director letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR 431.408(b)(2)).
- b. **Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments.** In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.
- c. **Public Notice.** The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

- 3.14. The 1115 demonstration will have no impact on American Indian and Alaska Natives (AI/AN) rights to exemption from enrollment in managed care organizations, or the requirements for CCOs and other managed care plans to come into compliance with the CMS 2390-F, regulations regarding Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability published April 26, 2016, including the AI/AN specific provisions at 42 CFR 438.14.
- 3.15. **Indian Health Care Providers.** Pursuant to 25 U.S.C. 1647a(a)(1), the state will accept an entity that is operated by Indian Health Service (IHS), an Indian tribe, tribal organization, or urban Indian health (collectively referred to as Indian Health Care Providers or "IHCP") program as a provider eligible to be enrolled with Oregon Medicaid and receive payment

under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity attests that it meets generally applicable state or other requirements for participation as a provider of health care services under the program.

- 3.16. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.17. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the single state Medicaid agency must maintain authority, accountability, and oversight of the program. The state Medicaid agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and any other contracted entities. The single state Medicaid agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 3.18. **Common Rule Exemption.** The state must ensure the only involvement of human subjects in research activities authorized and/or required by this demonstration is for projects conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration, as represented in these approved STCs, meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

- 4.1. **Eligibility.** This demonstration affects all mandatory Medicaid and CHIP eligibility groups set forth in Oregon's state plan and optional groups set forth in the state plan, except as otherwise noted in the waivers and expenditure authorities for this demonstration and in these STCs. Any Medicaid and/or CHIP state plan amendments to the eligibility groups apply to this demonstration.
- 4.2. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Oregon Health Authority (OHA). All individuals eligible under the Medicaid state plan, including those eligible through mandatory and optional groups, or 1115 expenditure authority, will receive either the OHP Plus benefit plan or the Alternative Benefits Plan approved in the Medicaid state plan.
 - a. **OHP Populations.** The state will provide health care coverage through the OHP programs defined within these special terms and conditions (STCs) to the Medicaid mandatory and optional groups under the Oregon state plans, as defined in Attachment C.

- b. **Applicability of Medicaid Laws and Regulations.** All requirements expressed in Medicaid laws, regulations and policies apply to all the populations affected by this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration.
- c. **Summary of OHP Benefit Structure.** The Oregon Health Plan demonstration has two components, offered directly through OHP Plus and the Alternative Benefit Plan. Most beneficiaries under either program receive services through managed/coordinated care delivery systems.

All beneficiaries receive the OHP Plus benefit (populations 1, 3, 4, 5, 6, 7, 8, 9, 10, 21, 23 and 24 in Attachment C), which consists of:

- i. All benefits covered under the approved state plan that are also consistent with the Prioritized List of Health Services to the extent that the state has authority under its section 1115 demonstration to apply the Prioritized List to coverage, through its waiver phase-out date (described in STC 4.2.d);
- ii. Prior to January 1, 2023, for children at or over 1 year and younger than 21 years old, and YSHCN, section 1905(a) services that are determined necessary to correct or ameliorate physical and mental illnesses and conditions, in accordance with the EPSDT definition at section 1905(r) of the Act, that are consistent with the Prioritized List;
- iii. Prior to January 1, 2023, for children under 1 year of age, section 1905(a) services that are determined necessary to correct or ameliorate physical and mental illnesses and conditions, in accordance with the EPSDT definition at section 1905(r) of the Act, regardless of their consistency with the state plan or the Prioritized List;
- iv. Beginning January 1, 2023, for all children younger than 21 years old, and YSHCN, all section 1905(a) services that are determined necessary to correct or ameliorate physical and mental illnesses and conditions, regardless of whether they are included in the state plan, in accordance with the EPSDT definition at section 1905(r) of the Act;
- v. Prior to January 1, 2027, for pregnant individuals, the entire Medicaid state plan Services Benefit Package, subject to necessary pre-authorization for services not consistent with the Prioritized List, through its waiver phase-out date;
- vi. Services of traditional health workers (described in STC 4.2.e);
- vii. Primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority, that were restricted or

eliminated from coverage subject to the Prioritized List effective January 1, 2010 for non-pregnant adults enrolled in OHP;

- viii. Services of patient-centered primary care homes (described in STC 4.2.f); and
- ix. The following Medicaid benefits to the extent otherwise provided under the state plan:
 - 1. Long Term Care Services;
 - a. Nursing Facility Services
 - b. Home- and Community-Based Services
 - c. Community Supported Living Services
 - d. Programs of All-Inclusive Care Elderly
 - 2. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services; and
 - 3. Medicare Premium Payments and Medicare cost sharing.
- d. **Prioritized List of Health Services.** One of the distinguishing features of the OHP demonstration is that OHP Plus benefits are based on the Prioritized List of Health Services (“the Prioritized List”, or, “the List”), which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services. The waiver of amount, duration, and scope as related to the Prioritized List will end by January 1, 2027. As of that date, the Oregon Health Plan must comply with all state plan rules, except as otherwise provided under this demonstration.
 - i. **Oversight -- The Health Evidence Review Commission (HERC).** The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Health Policy & Analytics Division. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.
 - ii. **Modifications to the Prioritized List.** Until January 1, 2027, modifications to the Prioritized List require federal approval through submission of an amendment, as described in STC 3.7, in order to ensure the Prioritized List is comprehensive enough to provide Medicaid beneficiaries with an appropriate

benefit package. A current version of the Prioritized List of Health Services is maintained by the state of Oregon at <https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx>. During the demonstration period and as specified below, the state will not reduce benefits.

- iii. **Ordering of the Prioritized List.** The Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g., common colds); (b) are primarily cosmetic in nature (e.g., benign skin lesions); or (c) have no effective treatments available (e.g., metastatic cancers).
- iv. **Updating the Prioritized List.** The Commission is charged with updating the list for every regular legislative session occurring in odd-numbered years. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.
- v. **Non-covered Condition and Treatment Pairs.** In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The state must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the Prioritized List of Health Services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The state shall provide, through a telephone information line and through the applicable appeals process under 42 CFR part 431 subpart E, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

- vi. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

1. The state will maintain the cutoff point for coverage at the same position on the Prioritized List relative to the 2022-2023 List for the remainder of the demonstration as noted above in STC 4.2.d.ii. For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request in compliance with STC 3.7 will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in STC 13.
 2. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.
 3. For a change to the list not defined above that meets the terms of STCs 3.6 and 3.7, an amendment request will be submitted to CMS.
- e. **Traditional Health Workers (THW).** THWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. THWs may serve individuals regardless of the delivery system in which they are enrolled.
- f. **Patient Centered Primary Care Homes (PCPCH).** The state includes PCPCH services in the OHP Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement.
- 4.3. **Alternative Benefit Plan.** The mandatory state plan group, new adult group (Population 23 in Attachment C), will receive a benefits package provided through the state's approved alternative benefit plan (ABP) in the Medicaid state plan. Under the authority for Secretary-approved coverage as an ABP, CMS is approving a package of benefits that the state has determined includes at least all essential health benefits as defined using the required process, and other benefits that are both: 1) covered in accordance with the traditional benefit package under the approved state plan and 2) consistent with the state's Prioritized List, as approved by the Secretary, to the extent that the state has authority under its section 1115 demonstration to apply the Prioritized List to coverage.

4.4. **Breast and Cervical Cancer Treatment Program (BCCTP).** Individuals determined to be eligible as specified in the state plan for BCCTP services (population 21 in Attachment C) will be enrolled in the Oregon Health Plan.

4.5. **Continuous Eligibility.**

a. **Affected Individuals.**

- i. Except as provided in STC 4.5.c, individuals ages zero through five, excluding individuals eligible for Medicaid on the basis of 42 CFR 435.217, who enroll in Medicaid or CHIP shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls; and
- ii. Except as provided in STC 4.5.c, individuals ages six and older, excluding individuals eligible for Medicaid on the basis of 42 CFR 435.217, who enroll in Medicaid or CHIP shall qualify for a 24-month continuous eligibility period.

b. **Continuous Eligibility Period.** The state is authorized to provide continuous eligibility for the populations and associated durations specified in Table 1, regardless of the delivery system through which these populations receive Medicaid or CHIP benefits. This provision shall be effective for beneficiaries through age 18 beginning with enrollments and renewals that are undertaken on or after the date when the continuous coverage requirement authorized by the Families First Coronavirus Response Act (FFCRA) ends. Subject to the effective date, once effective, coverage shall be continuous as specified below. For adult populations, this provision shall be effective beginning July 1, 2023 or after the date when the continuous coverage requirement authorized by the FFCRA ends, whichever is later.

- i. For children ages 0 through 5 who qualify for continuous eligibility until the end of the month in which their 6th birthday falls, the child's continuous eligibility period begins on the effective date of the child's eligibility under 42 CFR 435.915 or 457.340(g). The state will redetermine eligibility consistent with 42 CFR 435.916 or 457.343 when the child turns age 6, and if eligible, provide a 24-month continuous eligibility period consistent with the requirements in this demonstration for individuals ages 6 and older. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 4.5.c.
- ii. For individuals that qualify for 24 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915 or 457.340(g), or the effective date of the most recent renewal of eligibility. Given individuals are continuously eligible regardless of changes in circumstances (except as provided under STC 4.5.c), the state will conduct renewals of eligibility consistent with 42 CFR 435.916 or 457.343, as applicable, for individuals who qualify for 24 months of continuous eligibility at the end of the individual's continuous eligibility period. The state

will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 4.5.c.

Table 1. Eligible Populations and Associated Duration for Continuous Eligibility

Population	Duration of Continuous Eligibility
Children ages 0 through 5, excluding individuals eligible for Medicaid on the basis on 42 CFR 435.217	Until the end of the month in which their 6 th birthday falls
Individuals ages 6 and above, excluding individuals eligible for Medicaid on the basis on 42 CFR 435.217	24 months

Individuals who are eligible for Medicaid on the basis of 42 CFR 435.217 are not eligible for continuous eligibility. Continuous eligibility applies to Medicaid and CHIP enrollees in all other Oregon Health Plan eligibility categories, except as specified in STC 4.5.c.

- c. **Exceptions.** Notwithstanding STC 4.5.b, if any of the following circumstances occur during an individual’s designated continuous eligibility period, the individual’s Medicaid or CHIP eligibility shall be redetermined or terminated:
 - i. The individual is no longer an Oregon resident;
 - ii. The individual requests termination of eligibility;
 - iii. The individual dies; or
 - iv. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.
- d. **Beneficiary-Reported Information and Periodic Data Checks.** The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the state’s implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state’s verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d) or 457.380. The state must redetermine

eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) or 457.343 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j) or 457.380.

As part of a deliverable titled New Initiatives Implementation Plan (see STC 11.4), the state must submit a description of the processes to perform the verifications described above. Furthermore, the state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 11.6).

- e. **Annual Updates to Beneficiary Information.** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information, and must attempt to update beneficiary contact information on an annual basis, which may include annually checking data sources and partnering with coordinated care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d) or 457.380(f), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

In the New Initiatives Implementation Plan (see STC 11.4), the state must submit a description of the processes to update beneficiary contact information on an annual basis. Each demonstration year, through the Annual Monitoring Reports (see STC 11.6), the state must submit to CMS a summary of activities and outcomes from these efforts.

4.6. Youth with Special Health Care Needs (YSHCN).

- a. **Eligibility for YSHCN Benefits.** Beginning no earlier than July 1, 2023, individuals will be eligible for YSHCN benefits if they are between ages 19 and 26, have income up to 300 percent FPL, and meet at least one of the criteria below. Individuals must also have met the eligibility criteria prior to turning age 19. Individuals eligible for YSHCN benefits are eligible for 24 months of continuous eligibility as described in STC 4.5.a.ii.
 - i. Have one or more serious chronic conditions as represented by the Pediatric Medical Complexity Algorithm (PCMA)'s list of complex chronic conditions;
 - ii. Have a serious emotional disturbance or serious mental health issue;

- iii. Have a diagnosed intellectual or developmental disability in accordance with Oregon Administrative Rules governed by Oregon’s Office of Developmental Disabilities Services;
 - iv. Have an “Elevated Service Need” or functional limitations as determined by two or more affirmative responses to a screener; or
 - v. Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA’s non-complex chronic conditions as described in the New Initiatives Implementation Plan (see STC 11.4).
- b. **YSHCN Enrollment.** The effective date of enrollment is established by the state based on the determination that the individual is eligible and may begin receiving YSHCN services. An individual may enroll through one of the pathways below, if they meet the age requirement and are either:
- i. Eligible for an established Medicaid state plan eligibility group (in which case income is deemed to meet the financial criteria for the purpose of YSHCN) and meet the non-financial eligibility requirement for YSHCN; or
 - ii. Not eligible for an established Medicaid state plan eligibility group upon reaching age 19, but meet the financial and non-financial eligibility criteria for YSHCN.
- c. **YSHCN Benefits.** Individuals enrolled as YSHCN will receive YSHCN benefits as described in STC 4.2.c and HSRN services as described in STC 9. The state will ensure that individuals enrolled as YSHCN will be screened for specific HRSN and may qualify for related services for up to 12 months, unless otherwise specified in STC 9. The state will also ensure that individuals enrolled as YSHCN are reassessed for their HRSN at least annually.

5. DELIVERY SYSTEM

Health System

- 5.1. Health care services authorized under this demonstration may be provided through (1) fee-for-service (FFS) for beneficiaries who are not required to enroll into a CCO, except as outlined in STC 5.1.a, or (2) managed care organizations called Coordinated Care Organizations (CCOs). Individuals who are not required to enroll into a CCO or who may disenroll from a CCO in accordance with 42 CFR 438.52 or who do not have another CCO option in their geographic area, will receive their services through a FFS delivery system except as outlined in STC 5.1.a, as applicable.
- a. Individuals receiving covered health care services through the FFS delivery system may be required to receive dental services through a managed care delivery system.

- b. Patient Centered Primary Care Homes (PCPCH): the PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP beneficiaries whether they are enrolled with a CCO or served through the FFS delivery system.

5.2. The majority of health care services are provided through a managed care delivery system, CCOs. The CCOs provide medical, behavioral health services and dental services. The state contracts with CCOs.

a. Enrollment of OHP Populations into CCOs

- i. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.
 - 1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.
- ii. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled).
- iii. Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment.
- iv. Dually eligible individuals will be voluntarily enrolled in a CCO via passive enrollment pursuant to 42 CFR 438.54(c) with the option to opt out and return to FFS at any time.
 - 1. Dually eligible individuals will receive a ninety (90) day notice regarding passive enrollment in a CCO, where sufficient capacity exists.
 - 2. Dually eligible individuals who live in an area with two CCOs will be enrolled using the same process as other OHP members, which is based on previous enrollment, enrollment of other family members, and CCO area capacity limit.
 - 3. Dually eligible individuals who are enrolled in a dual eligible special needs plan (D-SNP) will be assigned to the affiliated CCO. Additionally, dually eligible individuals who are enrolled in a Medicare Advantage plan will be assigned to the affiliated CCO.
- v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.
- vi. OHA member transition strategies for FFS members with special considerations include:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:
 - a. Care management requirements based on the beneficiary's medical condition;
 - b. Considerations of continuity of treatment, services, and providers, including behavioral health referrals and living situations;
 - c. Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services);
 - d. Availability of medically appropriate medications under the CCO formulary; and
 - e. Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team.
2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.
3. For dually eligible individuals, CCOs will be required to provide a minimum 90-day continuity of care period.

Description of Delivery System

- 5.3. **Definition and Role of Coordinated Care Organizations.** CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR part 438 unless a requirement has been specifically identified in the waiver authorities as expressly waived or specified as not applicable to an expenditure authority for this demonstration. CCOs will provide a governance structure to align the specialized services under one managed care organization. CCOs will partner with OHA to further the state's implementation of PCPCH and utilization of Traditional Health Workers (THWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

- a. **CCO Governance and Organizational Relationships.**

- i. **Governance.** Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system

and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see STC 5.3.a.ii); and at least two members from the community at large to ensure that the organization's decision making is consistent with the community members' values.

- ii. **Community Advisory Council (CAC).** The CCOs are required to convene a CAC that includes representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be an ongoing council and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.
- iii. **Clinical Advisory Panel.** The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.
- iv. **Partnerships.** The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.
- v. **Community Health Needs Assessment.** Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The state encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

5.4. **Alternate Delivery System.** The FFS delivery system applicable to some demonstration populations will continue as described in STC 4.

5.5. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.

5.6. **Compliance with Managed Care Requirements.** The state must meet the requirements of 42 CFR part 438 unless a requirement of part 438 has been identified in the waiver authorities as expressly waived or specified as not applicable to an expenditure authority for this demonstration.

5.7. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**

- a. **Mandatory Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive benefits pursuant to STCs 4 and 5. The mandatory enrollment will apply only when the plans in the

geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR part 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to twelve (12) months. Table 2 below illustrates the mandatory and affirmative choice (i.e., “opt-in”) populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given¹
1, 3, 4, 5, 6, 7, 8, and 10	Individuals of the identified populations other than those footnoted. ²	Mandatory in	Other CCO if available; FFS with cause
21	Breast and Cervical Cancer Treatment Program	Mandatory in	Other CCO if available; FFS with cause
23	New eligible adults	Mandatory in	Other CCO, if available; FFS with cause
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
1-11, 21	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid state plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid state plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A

¹ See (b) below for more information on disenrollment/plan change options and timelines.

² Exceptions include individuals who are American Indian or Alaska Native who are permitted to enroll, but not mandatorily enrolled. Individuals who are dually eligible for Medicare and Medicaid will be passively enrolled with the option to opt out and return to fee-for-service at any time.

Medicaid state plan	Individuals who are Transplant Rx only	Out	N/A
24	MAGI Expanded Adult Program	Mandatory in	Other CCO, if available; FFS with cause

- b. **Disenrollment.** The information in Table 3 is applicable to all managed care enrollees.

Table 3. Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR part 438.
Eligibility Redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

- 5.8. **Network Adequacy and Access Requirements.** The state must ensure that any CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the state's quality strategy required by 42 CFR 438.340.
- 5.9. **Required Notice for Change in CCO Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.
- 5.10. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the state will implement contingency planning in consultation with CMS to assure enrollee continuity of care.
- 5.11. **Tribal Engagement and Collaboration Protocol.** The state, with tribes, Indian Health Service facilities, and urban Indian Health Programs, must develop and submit to CMS for approval of a Model Tribal Engagement and Collaboration Protocol (Attachment D) no later

than 90 calendar days after the demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment D of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

CCOs will be required to adopt either the state's Model CCO Tribal Engagement and Collaboration Protocol or a policy agreed upon in writing by the CCO and every tribe and Indian Health Care Provider (IHCP) in the CCO's region. The model protocol establishes minimum requirements, such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for IHCPs, and protocols for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and IHCP.

In addition to adopting the Model CCO Tribal Engagement and Collaboration Protocol, CCO governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on tribes in their region and IHCPs and on the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration among (a) tribes, IHS facilities, and urban Indian health programs and (b) CCOs and the state, will be described by the Model CCO Tribal Engagement and Collaboration Protocol (Attachment D).

6. CAPITATION RATES AND PERFORMANCE MEASURES

- 6.1. Principles for Payment Methods that Support the Three-Part Aim.** The state will employ the following concepts in its payment methods to CCOs:
- a. The state will transition to a payment system that rewards health outcomes improvement and not volume of services. As part of this transition, the state will ensure through its CCO contracts that value-based payment (VBP) arrangements, structured to improve quality and manage cost growth, are used by CCOs with their network providers. The state will continue to develop the CCO VBP Roadmap that describes how the state, CCOs and network providers will achieve a set target of VBP payments by the end of the demonstration period. The CCO VBP Roadmap provides a broad definition of VBP and includes a schedule that ensures phased-in implementation over the course of the demonstration. The state will work with CCOs and network providers to implement this CCO VBP Roadmap. To the extent that the state requires specific payment mechanisms that direct CCOs' expenditures under the contracts between the state and the CCOs, the state shall comply with 42 CFR 438.6(c).
 - b. The state will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services, other than specific services identified in non-risk payment arrangements with the CCOs.

- i. CCOs will be at risk for services included in the CCO Services Inventory, which will be appended as Attachment E. While the intent is to include as many services as possible within the global budget payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding any additional services to the global budget.

6.2. State Oversight of Medical Loss Ratio (MLR)

- a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.
 - i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf>. The state must submit its plan to operationalize STC 6.2.a through d to CMS for review and approval at DMCPMLR@cms.hhs.gov no later than April 1, 2023. This plan must outline key deliverables and timelines to meet the requirements of STC 6.2.a through d.
- b. Effective January 1, 2024, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.
- c. No later than January 1, 2025, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.
- d. STC 6.2.a, 6.2.b, and 6.2.c must apply for all of the following entities:
 - i. Risk-based plans for which the state receives federal financial participation for associated expenditures;
 - ii. Full and partially delegated plans;
 - iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 6.2.d.ii; and
 - iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 6.2.d.iii.
- e. The state must work with CMS to effectuate an audit of the MLR data covering all full rating periods of this 1115 demonstration renewal package. The audit must occur no sooner than April 1, 2026, and ideally later in 2027 to allow the state time to review and finalize the calendar year 2026 MLRs.

- f. The state will update the CCO contract language to require the CCOs to provide HRSN services as described in STC 9. When HRSN services are included in risk-based capitation rates, as outlined in STC 9.9.d, HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.
 - i. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 18 months prior to the implementation of HRSN services in risk-based capitation rates. The state shall submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.
- g. The state will update the CCO contract language to require the CCOs to consider using alternative services including “in lieu of services” pursuant to 42 CFR 438.3(e)(2), “health-related services” and “community benefit initiatives” described in 42 CFR 438.3(e)(1)(i) and 438.8(f)(3)(v), respectively. CCOs are at liberty to offer services not covered under the state plan, as allowed under 42 CFR 438.3(e)(1)(i). Since enrollees may need or benefit from additional services that are not in lieu of services, but could ultimately improve the enrollee's health, CCOs should consider providing these services as necessary.
 - i. For purposes of this STC, an “in lieu of service” is a setting or service that is determined by the state to be a medically appropriate and cost-effective substitute for a service or setting covered under the state plan. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).
 - ii. For the purposes of these STCs, “health-related services” are cost-effective services offered as an adjunct to covered benefits.
 - 1. Health-related services are not considered Medicaid covered services;
 - 2. Health-related services are intended to promote the efficient use of resources and, in many cases, target social determinants of health; unlike in lieu of services, health-related services are not substitutes for state plans services; and
 - 3. CCO expenditures for health-related services must be paid for from the CCO's savings from improved health and more efficient use of resources, and will not be included in capitation rate setting (except to the extent that such services may result in savings or performance-based incentives as described in STC 6.2.h).

- iii. For the purposes of these STCs, “community benefit initiatives” are community level interventions focused on improving population health and are defined in 42 CFR 438.8(f)(3)(v). CCO expenditures for community benefit initiatives must be paid for from the CCO’s savings from improved health and more efficient use of resources and should not be included in capitation rate setting.
- iv. The CCO contracts must not require CCOs to provide specific in lieu of services, health-related services, or community benefit initiatives, although the contract may require the CCOs to consider the use of such services when it could improve an enrollee’s health or promote the efficient use of resources. If the CCO elects to provide health-related services and/or community benefit initiatives, it must report these expenditures to the state using the procedures noted in the contract.
 - 1. An enrollee cannot be required to use an in lieu of service or a health-related service. A CCO’s offer to provide an in lieu of service or health-related service does not change the CCO’s obligation to provide all covered services under the contract between the state and the CCO.
 - 2. The state must comply with the contracting, reporting and rate-setting requirements for in lieu of services as specified in 42 CFR 438.3(e)(2).
 - 3. Using the information provided by the CCOs from a state-developed monitoring and oversight process, separate from the HRSN monitoring and oversight process, the state will report on the health-related services and/or community benefit initiatives provided through the CCO contracts, including the effectiveness of the services in improving health and deterring higher cost care.
 - 4. For purposes of Medical Loss Ratio reporting, CCOs must only include those expenditures under the contract between the state and the CCO that meet the inclusion criteria for the Medical Loss Ratio reporting as described in 42 CFR 438.8. To the extent that expenditures for health-related services meet the definition for: (a) activities that improve health care quality, as defined in 45 CFR 158.150; or (b) expenditures related to health information technology and meaningful use requirements, as defined in 45 CFR 158.151, those expenditures shall be included in the numerator of the Medical Loss Ratio as described in 42 CFR 438.8(e)(3). Community benefit initiatives that meet the definition in 45 CFR 158.162(c) may be included in the MLR denominator as an adjustment to premium revenue subject to the limits stated in 42 CFR 438.8(f)(3)(v).
- h. The contract between the CCOs and state may include performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. That is, the contract may include incentives to encourage CCOs’ creative use of health-related service delivery to improve health outcomes and reduce growth in per capita expenditures.

- i. As CCOs provide health-related services that are more cost-effective than state plan services, the per capita growth rate for covered services in capitation rates should decrease relative to what it would have been in absence of health-related services. The state will offset the decrease with changes in the methodology to develop capitation rates; the rates will be developed and documented consistent with requirements in STC 5.6. Specifically, the state will develop capitation rates with an underwriting margin that varies by CCO, as opposed to a fixed percentage of premium for each CCO. The capitation rates for CCOs identified as high performing (i.e., those showing quality improvement and cost reduction in the previous years) will have a higher percentage of underwriting margin built into their capitation rates than lower performing CCOs.
- ii. The state will establish an incentive or withhold arrangement or a combination of incentive and withhold arrangements. Whether the financial structure is an incentive, withhold, or combination of the two, the arrangement will be designed to incentivize improvements and therefore referred to as an incentive. Incentives must be designed to reduce costs and improve health care outcomes. When developing the incentive, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing. The incentive will comply with the relevant portions of 42 CFR 438.6(c). The state will alert the CCOs that the incentive will be tied to each CCO's performance on the quality and access metrics established under STC 7, and that the whole incentive amount will be at risk.
- iii. Incentives must be correlatively reflected in the CCO/provider agreements to ensure that a portion of the incentives are passed through to providers to reflect the arrangement with the state-CCO contract. The state's contracts with CCOs must require that incentive payment contracts between CCOs and providers have a defined effective period that can be tied to the applicable MLR periods and must be signed and dated by all appropriate parties before the commencement of the applicable effective period. In addition, all incentive payment contracts must include defined metrics that the provider must meet to receive the incentive payment and specify a payment methodology that can be clearly linked to successful completion of such metrics including when the payment will be made. The state's contracts with the CCOs must include language prohibiting the use of attestations as the sole supporting documentation for provider payment data that are included in MLR reporting.
- iv. Consistent with Table 4, each subsequent demonstration year's capitation rates and incentives will be set in the demonstration year preceding the implementation in order to apply program experience as the program matures (e.g., DY21 rates and incentives will be set in DY20). The state will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

Table 4. Demonstration Years.

Demonstration Year	Time Period
20	July 1, 2021 – September 30, 2022
21	October 1, 2022 – September 30, 2023
22	October 1, 2023 – September 30, 2024
23	October 1, 2024 – September 30, 2025
24	October 1, 2025 – September 30, 2026
25	October 1, 2026 – September 30, 2027

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

- 7.1. **Overview.** Improving access and quality is a key component of the state health system transformation and measurement is necessary to determine whether the demonstration’s goal of advancing the triple aim is met.
- 7.2. **Incentive Metrics Governance.** The state’s strategy for robust measurement includes public processes to inform decisions about which measures to incentivize, where to set benchmarks, and how to prioritize needs for new metrics. This public process will include one or more public committees, in accordance with Oregon statutes that address decision-making for the metrics program.
- 7.3. **Utilization of New Services.** The state and CCOs must track discrete services to identify whether the service is a state plan service or other service paid for with Medicaid funds under the capitation rate or a non-risk basis and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement and as required by 42 CFR 438.242.
- 7.4. **Quality and Access Data Reporting from the State to CMS.** In accordance with STC 11.6, the state will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the state will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 90 days of the demonstration approval, the state will submit and CMS will approve a reporting format.
- 7.5. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**
- a. **Statewide quality, access, and expenditure monitoring and analysis.** The state shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The state

must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights.

- b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within thirty (30) days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to technical assistance, improvement plans, development of guidance, and/or focused learning collaboratives or workgroups to target underlying issues affecting outcomes, performance, access and cost.
- c. **Additional actions taken if goals are not achieved.** If the interventions undertaken pursuant to STC 7.5.b do not result in improved performance in identified areas of concern within ninety (90) days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the state placing the CCO on a corrective action plan. The state must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts.

- 7.6. **External Quality Review Organization.** The state is required to meet all requirements found in 42 CFR 438.364. The state must finalize the annual technical report by April 30th of each year, make available to CMS and post the most recent copy of the annual EQR technical report on the state's website as required under 42 CFR 438.10(c)(2) by April 30th of each year. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

8. DESIGNATED STATE HEALTH PROGRAMS

- 8.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs subject to the limits described below. This DSHP authority will allow the state to support DSHP-Funded Initiatives, as described in STC 4.6 and 9. This DSHP authority will be available from DY21-DY25.
- a. The DSHP will have an established limit in the amount of \$535 million total computable expenditures, in aggregate, for DY21-DY25.
 - b. The state may claim FFP for up to the annual amounts outlined in Table 5, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to

one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year.

Table 5. Annual Limits in Total Computable Expenditures for DSHP.

	DY21	DY22	DY23	DY24	DY25
Total Computable Expenditures	\$51 million	\$182 million	\$143 million	\$159 million	\$0 million

- c. The state must contribute \$71 million in original, non-freed up DSHP funds, for the 5-year demonstration period towards its initiatives described in STC 4.6 and 9. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.
- d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.
- e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the demonstration approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. Only after CMS approves the list and ensures that none of the requested state programs fall within the exclusions listed in STC 8.2 can the state begin claiming FFP for DSHP expenditures. The Approved DSHP List will be appended to the STCs as Attachment F.

8.2. Prohibited DSHP Expenditures.

- a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.
- b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, two percent of total provider expenditures or claims through DSHP

identified as described in STC 8.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 8.1.

- c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:
 - i. Bricks and mortar;
 - ii. Shelters, vaccines, and medications for animals;
 - iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;
 - iv. Revolving capital funds; and
 - v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

8.3. DSHP-Funded Initiatives.

- a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.
- b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. Funding for DSHP-funded initiatives will not be supplanting, nor merely supplementing existing services or programs. DSHP-funded initiatives must be new services or programs within the state. Funding for DSHP-funded initiatives specifically associated with infrastructure start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.
- c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

- i. Youth with Special Health Care Needs
- ii. HRSN Services
- iii. HRSN Infrastructure

8.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS, within 150 calendar days of the approval of the OHP Demonstration, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to receive FFP until the protocol is approved by CMS. Once approved by CMS, the protocol will be appended as Attachment G to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

- a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:
 - i. Certification or attestation of expenditures.
 - ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 8.2.
- b. The state will claim FFP for DSHP quarterly based on actual expenditures.

8.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

- a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that the DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.
- b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.
- c. DSHP will be claimed at the general administrative matching rate of 50 percent.
- d. Expenditures will be claimed in accordance with CMS-approved DSHP Claiming Protocol in Attachment G.

- 8.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than December 31, 2025, after the approval of this authority. Upon CMS approval, the plan will be appended as Attachment H to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

9. HEALTH-RELATED SOCIAL NEEDS

- 9.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for the specified evidence-based HRSN services identified in STC 9.2, subject to the restrictions described below and in STC 10. Expenditures for HRSN services are limited to costs not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to beneficiaries through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; beneficiaries can opt out of HRSN services at any time; and HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services to CMS as outlined in STC 9.6 and Attachment J.
- 9.2. **Allowable HRSN services.** The state may cover the following HRSN services:
- a. Housing Supports, including:
 - i. Rent/temporary housing for up to 6 months, specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care
 - ii. Utility costs including activation expenses and back payments to secure utilities, limited to individuals receiving rent/temporary housing as described in STC 9.2.a.i
 - iii. Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention
 - iv. Housing transition navigation services

- v. One-time transition and moving costs (e.g., security deposit, first-month's rent, utilities activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture)
 - vi. Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification
 - vii. Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention
 - viii. Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation
- b. Nutrition Supports
- i. Nutrition counseling and education, including on healthy meal preparation
 - ii. Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months
 - iii. Meals or pantry stocking for children under 21, YSHCN, and pregnant individuals, up to 3 meals a day delivered in the home or private residence, for up to 6 months
 - iv. Fruit and vegetable prescriptions, for up to 6 months
- c. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees

9.3. HRSN Infrastructure.

- a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to STC 10. This FFP will be available for the following activities:
 - i. Technology – e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tool and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems
 - ii. Development of business or operational practices – e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation

- iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures
 - iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening
- b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 6. Annual Limits in Total Computable Expenditures for HRSN Infrastructure

	DY21	DY22	DY23	DY24	DY25
Total Computable Expenditures	\$51M	\$53M	\$5M	\$5M	\$5M

- c. Infrastructure investments will receive the applicable administrative match for the expenditure.
- d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures are not factored into managed care capitation payments, and that there is no duplication of funds.
- e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure, and Provider Qualifications for HRSN Services is approved, as described in STC 9.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.
- f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS’s consideration.

9.4. Excluded HRSN services. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

- a. Construction costs (bricks and mortar), except as needed for approved medically-necessary home modifications as described in STC 9.2.a.viii;
- b. Capital investments;
- c. Room and board, except as described in STCs 9.2.a.i and 9.2.b.ii through iv;

- d. Research grants and expenditures not related to monitoring and evaluation;
- e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;
- f. Services provided to individuals who are not lawfully present in the United States or are undocumented;
- g. Expenditures that supplant services and activities funded by other state and federal governmental entities;
- h. School-based programs for children that supplant Medicaid state plan programs;
- i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and
- j. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this demonstration.

9.5. **Covered Populations.** Expenditures for HRSN services may only be made for the targeted populations specified below. To receive HRSN services, individuals in the targeted populations must have a documented need for the services and the services must be determined medically appropriate, as further described in STC 9.6, for the documented need. Medical appropriateness must be based on clinical and social risk factors. This determination must be documented in the beneficiary's care plan or medical record. The allowable targeted populations are:

- a. Youth with Special Health Care Needs (YSHCN) ages 19-26 as described in STC 4.6;
- b. Adults and youth discharged from an IMD;
- c. Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities;
- d. Youth involved in the child welfare system, including youth transitioning out of foster care;
- e. Individuals transitioning from Medicaid-only to dual eligibility status;
- f. Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; and
- g. Individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon.

9.6. **Protocols for HRSN Infrastructure and HRSN Services.** The state must submit, for CMS approval, the Protocol for HRSN Infrastructure and the Protocol for HRSN Services. The

state may not claim FFP for HRSN Infrastructure or HRSN Services expenditures until CMS approves the respective Protocol. Each Protocol may be submitted and approved separately. Once approved, the state may claim FFP for HRSN Infrastructure and HRSN Services expenditures retrospectively to the beginning of the demonstration approval date. The protocols for HRSN Infrastructure and HRSN Services may be updated as details are changed or added. The approved Protocols will be appended to the STCs as Attachment J.

- a. The Protocol for HRSN Infrastructure must include proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.
- b. The Protocol for HRSN Services must include:
 - i. A list of the covered HRSN services (not to exceed those allowed under STC 9.2), with associated service descriptions and service-specific provider qualification requirements
 - ii. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable
 - iii. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate
 1. Plan to identify medical appropriateness based on clinical and social risk factors
 2. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders
 - iv. A description of the process for developing care plans based on assessment of need
 1. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening
 2. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed

9.7. **Provider Network Capacity.** The state must require CCOs to ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid agency guidance.

9.8. **Contracted Providers.** The following requirements must be consistent with CCO and/or any other applicable vendor contracts and are applicable to all HRSN services.

- a. The state must require CCOs and/or other applicable vendors to contract with HRSN service providers (“Contracted Providers”) to deliver HRSN services authorized under the demonstration, as applicable.
- b. The state must require CCOs and/or other applicable vendors to establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of their applicable HRSN services. Contracted Providers do not need to be licensed unless otherwise required by the state; however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.
- c. Any state direction on payment arrangements for HRSN services that constitutes a state directed payment must satisfy the requirements in 42 CFR 438.6(c).

9.9. **Service Delivery.** HRSN services will be provided both through the FFS system and through the state’s existing CCO network. In accordance with STC 5.1, individuals who are not required to enroll into a CCO or who may disenroll from a CCO will receive HRSN services through a FFS delivery system.

- a. HRSN services will be available from all CCOs and must be included in the managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).
- b. CCOs will provide all HRSN services authorized under this demonstration through contracted network providers.
- c. CCOs must offer the services in all service areas in which the CCO operates.
- d. It is permissible for HRSN services to be paid via a non-risk payment to the CCOs. For a non-risk payment, the CCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, HRSN services may be paid on a fee-for-service basis by the state as defined in 42 CFR 447.362. If the state chooses to instead incorporate the HRSN services into risk-based capitation rates, it must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, and 438.7.

9.10. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

9.11. **Person-Centered Service Plan.** The state shall ensure that there is a person-centered service plan for each individual determined to be eligible for HRSN services. The person-centered service plan must be person-centered, identify the individual’s needs and individualized

strategies and interventions for meeting those needs, and be developed in consultation with the individual and the individual's chosen support network as appropriate. The person-centered service plan will be reviewed and revised upon reassessment of need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

- 9.12. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state agrees that appropriate separation of assessment, service planning and service provision functions are incorporated into state, CCO, and other applicable vendors' conflict of interest policies.
- 9.13. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:
- a. Beneficiary and plan protections, including but not limited to:
 - i. HRSN services must not be used to reduce availability of, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.
 - ii. Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if HRSN services were not an option.
 - iii. Medicaid beneficiaries always retain the right to file appeals and/or grievances pursuant to 42 CFR 438.
 - iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they have requested, are currently receiving, or have previously received HRSN services.
 - v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.
 - b. Managed care plans must timely submit data when requested by the state or CMS, including, but not limited to:
 - i. Data to evaluate the utilization and effectiveness of the HRSN services.
 - ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken to inform health equity efforts and efforts to mitigate health disparities.
 - iii. Any data necessary to monitor appeals and grievances for beneficiaries.

- iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.
 - v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.
- c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:
- i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. The state must seek CMS approval on what is considered appropriate and reasonable timeframe for plan submission of encounter data. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken, to inform health equity efforts and efforts to mitigate health disparities undertaken by the state.
 - ii. Any additional information requested by CMS, the state, or another legally authorized oversight body to aid in ongoing evaluation of HRSN services or any independent assessment or analysis conducted by the state, CMS, or another legally authorized independent entity.
 - iii. Any additional information determined reasonable, appropriate and necessary by CMS.

9.14. **Rate Methodologies.** All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to fee-for-service payment as well as non-risk payments and capitation rates in managed care delivery systems, as part of the New Initiatives Implementation Plan (see STC 11.4) at least 60 days prior to implementation. States must submit all documentation requested by CMS, including but not limited to the payment rate methodology as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting fee-for-service payment rates.

9.15. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for social services related to housing transition supports and nutrition supports for the duration of the demonstration. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the New Initiatives Implementation Plan (see STC 11.4) that outlines how it will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 11.6, including any justifications necessary to describe the findings.

9.16. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and

nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the person-centered plans as appropriate. The state will submit a plan to CMS as part of the New Initiatives Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly Monitoring Reports described in STC 11.6, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Quarterly Monitoring Reports.

10. PROVIDER PAYMENT RATE INCREASE REQUIREMENT

- 10.1. The provider payment rate increase requirements described hereafter are a condition for both DSHP and HRSN expenditure authority as referenced in Expenditure Authorities 5, 6, and 7.
- 10.2. As a condition of approval and ongoing provision of FFP in DSHP and HRSN expenditures over this demonstration period of performance, DY21 through DY25, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.
- 10.3. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this STC 10. Additionally, the state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this STC 10 (i.e., cost-shifting).
- 10.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this STC 10, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health services.

- 10.5. By December 31, 2022, and if the state makes fee-for-service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:
- a. Provide to CMS the average Medicaid to Medicare provider rate ratios if applicable for each of the three categories of services as these ratios are calculated for the state and service category as noted in the following sources:
 - i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); and
 - ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3); OR
 - b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:
 - i. Service codes must be representative of each service category as defined in STC 10.4;
 - ii. Medicaid and Medicare data must be from the same year and not older than 2019; and
 - iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.
- 10.6. To establish the state's ratio for each service category identified in STC 10.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:
- a. The average fee-for-service ratio as provided in STC 10.5.a, if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan fee-for-service payment rate schedules); or

- b. The data and methodology for any or all of the service categories as provided in STC 10.5.b using Medicaid managed care provider payment rate and utilization data.
- 10.7. In determining the ratios required under STC 10.5 and 10.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).
- 10.8. If the state is required to increase provider payment rates for managed care plans per STC 10.2 and 10.6, the state must:
 - a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and
 - b. Ensure that the entirety of a two percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
- 10.9. For the entirety of DY23 through DY25, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate at any time in DY21 for each service (including any facility and provider modifiers), and such rate will be in effect on the first day of DY23. A required payment rate increase for a delivery system shall apply to all services in a service category as defined under STC 10.4.
- 10.10. If the state uses a managed care delivery system for any of the service categories defined in STC 10.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY23 through DY25, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate for each service in DY21 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 10.4.
- 10.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY23 (or, as applicable, the first day of the first rating period that starts in DY23), the state will provide an alternative effective date and rationale for CMS review and approval.
- 10.12. The state will provide the information to document the payment rate ratio required under STC 10.5 and 10.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.
- 10.13. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report

that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

- 10.14. No later than December 31, 2022, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 10.5 and 10.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment K:

Oregon Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to provider payment rate increase requirements for the demonstration period of performance DY21 thru DY25		
Category of Service	Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio	Medicaid Managed Care to Medicare Fee-for-Service Ratio
Primary Care Services	<i>[insert percent, or N/A if state does not make Medicaid fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 10.5.a or STC 10.5.b]</i>	<i>[insert approach, either ratio derived under STC 10.6.a or STC 10.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Obstetric Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 10.5.a or STC 10.5.b]</i>	<i>[insert approach, either ratio derived under STC 10.6.a or STC 10.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Behavioral Health Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system]</i>

		<i>for applicable covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 10.5.a or STC 10.5.b]</i>	<i>[insert approach, either ratio derived under STC 10.6.a or STC 10.6.b; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>

In accordance with STCs 10.1 through 10.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment rate increases for each service will be effective beginning on *[insert date]* and will not be lower than the highest rate for that service code in DY21, including any modifiers or qualifiers such as facility type, plus an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points relative to the rate for the same or similar Medicare billing code through at least *[insert date]*.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under a managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and provider types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under a managed care delivery system, the data and methodology for any one of the service categories as provided in STC 10.6.b will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b.]

☐ a. The effective date of the rate increases is the first day of DY23 and will be at least sustained, if not higher, through DY25.

☐ b. Oregon has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing the provider payment rate increase on the first day of DY23. Oregon will effectuate the rate increases no later than the

<p>CMS approved date of <i>[insert date]</i>, and will sustain these rates, if not made higher, through DY25.</p>
<p>Oregon <i>[insert does or does not]</i> make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.</p> <p>For any such payments, I agree to submit by no later than <i>[insert date]</i> for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than <i>[insert date]</i></p>
<p>Oregon <i>[insert does or does not]</i> include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.</p> <p>For any such payments, I agree to submit the Medicaid managed care plans' provider payment rate increase methodology, including the information listed in STC 10.7 through the state-directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than <i>[insert date]</i>.</p>
<p>If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 10.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.</p>
<p>Oregon agrees not to use DSHP funding to finance any provider payment rate increase required under STC 10, and will ensure that the entirety of a two-percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.</p> <p>Oregon further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 10.</p>
<p>I, <i>[insert name of SMD or CFO (or equivalent position)]</i> <i>[insert title]</i>, attest that the above information is complete and accurate.</p> <p><i>[Provide signature_____]</i></p> <p><i>[Provide printed name of signatory_____]</i></p>

[Provide date _____]

11. GENERAL REPORTING REQUIREMENTS

- 11.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in STC 11.1.b; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state’s anticipated date of submission. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.

If CMS agrees to an interim corrective process in accordance with STC 11.1.b, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

- c. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

- 11.2. **Submission of Post-Approval Deliverables.** The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes as stipulated by CMS and within the timeframes outlined within these STCs.
- 11.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:
- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
 - b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
 - c. Submit deliverables to the appropriate system as directed by CMS.
- 11.4. **New Initiatives Implementation Plan.** The state is required to submit a New Initiatives Implementation Plan ("Implementation Plan") to cover certain key policies being tested under this demonstration, including those approved through any amendments. The Implementation Plan will contain applicable information for the following expenditure authorities: YSHCN, HRSN Infrastructure, HRSN Services, and Continuous Eligibility. The Implementation Plan, at a minimum, must provide a description of the state's strategic approach to implementing these demonstration policies, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

The state must submit the Maintenance of Effort information required by STC 9.15 and 11.4.i for CMS approval no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted for CMS approval no later than 9 months after the approval of this demonstration. The state must submit any required clarifications or revisions to their Implementation Plan submission within 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment L and may be further altered only with CMS approval.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the demonstration policies that are not already captured in the STCs or available elsewhere publicly. Furthermore, for the state's HRSN-related authorities, the Implementation Plan does not need to repeat any information submitted to CMS in the Protocols for HRSN Infrastructure and HRSN Services (see STC 9.6); however, as

applicable, the information provided in the two deliverables must be aligned and consistent with one another.

The Implementation Plan does not need to duplicate information that pertains to more than one initiative, assuming the information is the same. The Implementation Plan can be updated as necessary to align with state operations. CMS may provide the state with a template to support the state in developing and obtaining approval of the Implementation Plan.

The New Initiatives Implementation Plan must include information on, but not limited to, the following:

- a. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation
- b. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries)
- c. Plans for changes to information technology (IT) infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision.
- d. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state
- e. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs
- f. A description of processes to perform verifications on beneficiary residency and other checks and to update beneficiary contact information on an annual basis, as described in STCs 4.5.d and e
- g. A plan to finalize information as required by STC 4.6.a.v (YSHCN eligibility criteria)
- h. Information as required per STC 9.14 (HRSN Rate Methodologies)
- i. Information as required per STC 9.15 (MOE)

- j. Information as required per STC 9.16 (Partnerships with State and Local Entities)

Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of authority for YSHCN, HRSN Infrastructure, HRSN Services, and/or Continuous Eligibility under this demonstration.

- 11.5. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment M. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.
 - a. At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 11.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.
 - b. For the HRSN services authorized through this demonstration, the Monitoring Protocol also requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines. This slate of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track performance relative to the goals and milestones, as provided in the implementation plan, for the HRSN infrastructure investments.

- c. In addition, the state must describe in the Monitoring Protocol methods to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to: (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), and (4) social needs screening results from electronic health records, health plans, or other partner agencies, as applicable. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.
- d. For the qualitative elements (e.g., operational updates as described in STC 11.6), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

11.6. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

- b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration’s program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries’ outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.
- i. The demonstration’s metrics reporting must cover categories including, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration’s policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration’s initiatives help improve outcomes for the state’s Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state’s reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) “disparities-sensitive” measures) and prioritize key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.
- ii. For this demonstration’s HRSN initiatives, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. In alignment with STC 9.16, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies to leverage their expertise and existing housing and nutrition resources instead of duplicating services. Furthermore, the state’s enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide

status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

- iii. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must – at a minimum – capture data on utilization of preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.
- iv. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of disparities-sensitive metrics described above, with applicable demographic stratification. In addition, the state must demonstrate through its annual monitoring reporting to CMS improvements in Medicaid fee-for-service base provider reimbursement rates and reimbursement rates for providers enrolled in managed care to the extent required by STC 10.
- v. As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state’s HRSN initiatives and the DSHP-funded initiatives.
- vi. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

- c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in STC 13, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately on the CMS-64.
- d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

- 11.7. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state

corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

- 11.8. **Phase-out of Waiver Authority Related to the Prioritized List.** The state's waiver of amount, duration, and scope related to the Prioritized List, authorized in the original 1994 approval, will be phased out of the OHP demonstration by January 1, 2027. Use of this waiver authority will continue until January 1, 2027 while the state coordinates with CMS and its Legislature to authorize and implement its termination. Oregon will also be required to submit a phase-out plan that will assure all mandatory state plan benefits are available to eligible OHP beneficiaries. The plan must include activities the state will perform, during the demonstration period, that will effectuate the phase-out, including timelines for submission of any necessary state plan amendments, as described in STC 3.9.
- a. **Phase-out Plan.** The state must submit a phase-out plan to CMS, no less than six months prior to the expiration of the relevant waiver of amount, duration, and scope on December 31, 2026. Prior to submission of the plan to CMS, the state must publish on its website, the draft phase-out plan for a thirty-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty-day public comment period has ended, the state must provide a summary of the comments received and any state changes to the phase out plan based on those comments. This Prioritized List Phase-Out Plan will be appended to these STCs as Attachment N.
- 11.9. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.
- a. The Close-Out Report must comply with the most current guidance from CMS.
 - b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.7 and 15.8, respectively.
 - c. The state will present to and participate in a discussion with CMS on the Close-Out report.

- d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
- e. A revised Close-Out Report is due to CMS no later than 30 days after receipt of CMS's comments.
- f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 11.1.

11.10. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

11.11. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

12. GENERAL FINANCIAL REQUIREMENTS

- 12.1. Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 12.2. Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these

expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

12.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
- b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

12.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible

for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.
- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

12.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

12.6. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by section 1903(w)(4) of the Act and 42 CFR 433.68(f).
- e. All provider related-donations as defined by 42 CFR 433.52 are bona fide as defined by section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

12.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 11.1. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

12.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in STC 13:

- a. Administrative costs, including those associated with the administration of the demonstration;

- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

- 12.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.
- 12.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. Table 7 provides a master list of MEGs defined for this demonstration.

Table 7. Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Parent Caretaker Relative (PCR)	Main	X		X	Medicaid-mandatory low-income families (Parents/Caretaker relatives and their children)
PWO	Main	X		X	Pregnant Individuals
CMO	Main	X		X	Children ages 0-18
BCCP	Main	X		X	Uninsured or underinsured under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program
Old Age Assistance	Main	X		X	Seniors age 65+; people with permanent disabilities
Aid to Blind/Disabled	Main	X		X	Blind and Disabled Individuals
Foster Children	Main	X		X	Foster Children
Supplemental Vision/Dental	Main			X	

Coverage for Tribes					
Designated State Health Programs	Main			X	
ACA Adults	Hypo	X		X	Low-income adults at 0%-133% FPL
YSHCN	Hypo	X		X	Youth age 19-26 with multiple chronic health care needs
Continuous Eligibility (CE) PCR	Hypo	X		X	Medicaid-mandatory low-income families (Parents/Caretaker relatives and their children)
CE PWO	Hypo	X		X	Pregnant Individuals
CE CMO	Hypo	X		X	Children ages 0-18
CE BCCP	Hypo	X		X	Uninsured or underinsured under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program
CE Old Age Assistance	Hypo	X		X	Seniors age 65+; people with permanent disabilities
CE Aid to Blind/Disabled	Hypo	X		X	Blind and Disabled Individuals
CE Foster Children	Hypo	X		X	Foster Children
HRSN Services	Capped Hypo		X	X	Health-Related Social Needs services
HRSN Infrastructure	Capped Hypo		X	X	Infrastructure costs related to the provision of HRSN services
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.
MAGI Expanded Adult Program	Hypo	X		X	Adults ages 19-64 with incomes from 133% up to and including 200% FPL

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver;

WW – with waiver

Oregon Health Plan

Demonstration Approval Period: October 1, 2022 through September 30, 2027

Amended: April 20, 2023

12.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00415/10). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in Table 7 as WW must be reported for expenditures, as further detailed in Table 8. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
- c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on Table 7 or in STC 13,

administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

- e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in STC 11.6, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in Table 7, and as also indicated in Table 8, with the exception of the Continuous Eligibility (CE) MEGs. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information. CE MEGs will report a calculated number of member months. Each CE MEG will report a percentage of the actual member months of the corresponding non-CE MEG. The corresponding non-CE MEG member months will then be reduced by the same percentage. For the CE CMO and CE Foster Children MEGs, this percentage will be 0.11%. For all other CE MEGs, this percentage will be 2.6%. For example, the actual member months for the Pregnant Individuals MEG will be reduced by 2.6 percent and the equivalent member months will be reported on the CE Pregnant Individuals MEG so that the total member months between the two MEGs are equal to the actual member months for the Pregnant Individuals group.
- f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 8. MEG Detail for Expenditure and Member Month Reporting							
MEG (Waiver Name)	Detailed Description	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
PCR	Medicaid-mandatory section 1931 low-income families (Parents, Caretaker relatives, and their children)	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
PWO	Pregnant Individuals	Follow CMS 64.9	Date of service	MAP	Y	10/1/2022	09/30/2027

		Base Category of Service Definition					
CMO	Children 0-18	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/ 2022	09/30 /2027
BCCP	Uninsured or underinsured under the age of 65 receiving treatment under services for the Breast and Cervical Cancer Treatment Program (BCCTP)	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/ 2022	09/30 /2027
Old Age Assistance	Seniors age 65+; people with permanent disabilities	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/ 2022	09/30 /2027
Aid to Blind/ Disabled	Aged, Blind and Disabled	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/ 2022	09/30 /2027
Foster Children	Foster care/ Substitute Care Children (Youth to age 26, if already in Oregon Foster Care; Youth to age 18, if in the Oregon Tribal Foster Care)	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/ 2022	09/30 /2027
ACA Adults	Low-income expansion adults	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/ 2022	09/30 /2027

YSHCN	Youth ages 19-26 with multiple chronic health care needs	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE PCR	Medicaid-mandatory section 1931 low-income families (Parents, Caretaker relatives, and their children) who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE PWO	Pregnant Women who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE CMO	Children 0-18 who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE BCCP	Uninsured or underinsured under the age of 65 receiving treatment under services for the Breast and Cervical Cancer Treatment Program (BCCTP) who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE Old Age Assistance	Seniors age 65+; people with permanent disabilities who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027

CE Aid to Blind/ Disabled	Aged, Blind and Disabled who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE Foster Children	Foster care/ Substitute Care Children (Youth to age 26, if already in Oregon Foster Care; Youth to age 18, if in the Oregon Tribal Foster Care) who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
HRSN Services	Report all expenditures for HRSN initiatives, excluding infrastructure	Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ ADM	N	10/1/2022	09/30/2027
HRSN Infrastructure	Report all expenditures for HRSN infrastructure	Follow standard CMS 64.10 Category of Service Definitions	Date of service	ADM	N	10/1/2022	09/30/2027
ADM	Report additional administrative costs that are directly attributable to the demonstration, are not described elsewhere, and are not subject to budget neutrality	Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/2022	09/30/2027
MAGI Expanded Adult Program	Adults 19-64 with incomes from 133 up to and including 200 percent FPL, already enrolled in OHP and determined	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	04/X/2023	09/30/2027

	ineligible due to income restrictions						
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ADM – administration; DY – demonstration year; MAP – medical assistance payments;
MEG – Medicaid expenditure group;

- 12.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in Table 9.

Table 9. Demonstration Years		
Demonstration Year 21	October 1, 2022 to September 30, 2023	12 months
Demonstration Year 22	October 1, 2023 to September 30, 2024	12 months
Demonstration Year 23	October 1, 2024 to September 30, 2025	12 months
Demonstration Year 24	October 1, 2025 to September 30, 2026	12 months
Demonstration Year 25	October 1, 2026 to September 30, 2027	12 months

- 12.13. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the state’s regular Title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the state to update this percentage to the more accurate figure, as supported by the state’s proposed methodology and data.
- 12.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 12.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state’s regular Title XIX FMAP rate.
- 12.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the

demonstration's actual expenditures to the budget neutrality expenditure limits described in STC 13. CMS will provide technical assistance, upon request.³

- 12.16. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 12.17. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
 - b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by

³ Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

12.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once a demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 12.18.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration, are outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will only be made for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
 - i. Provider rate increases that are anticipated to further strengthen access to care;
 - ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors (such as not aging data correctly) or unintended omission of certain applicable costs of services for individual MEGs;
 - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
 - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
 - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
 - vi. High cost innovative medical treatments that states are required to cover; or,

- vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
 - i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
 - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

13. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 13.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, three Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 13.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 7 and Table 8. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 13.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual or CE calculated number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The

annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

- 13.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government’s Medicaid costs would likely have been absent the demonstration, and that federal Medicaid “savings” have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. Table 10 identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as “WOW Only” or “Both” are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as “Both.”

Table 10. Main Budget Neutrality Test									
MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
PCR	PC	Both	\$715.99	5.2%	\$762.83	\$802.50	\$844.23	\$888.13	\$934.31
PWO	PC	Both	\$2,160.20	5.2%	\$2,301.51	\$2,421.19	\$2,547.09	\$2,679.54	\$2,818.88
CMO	PC	Both	\$482.05	5.0%	\$512.36	\$537.98	\$564.88	\$593.12	\$622.78

Table 10. Main Budget Neutrality Test									
MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
BCCP	PC	Both	\$2,273.78	5.2%	\$2,422.52	\$2,548.49	\$2,681.01	\$2,820.42	\$2,967.08
Old Age Assistance	PC	Both	\$700.37	4.3%	\$738.22	\$769.96	\$803.07	\$837.60	\$873.62
Aid to Blind/ Disabled	PC	Both	\$1,960.72	4.8%	\$2,079.06	\$2,178.85	\$2,283.43	\$2,393.03	\$2,507.90
Foster Children	PC	Both	\$802.34	5.0%	\$852.80	\$895.44	\$940.21	\$987.22	\$1,036.58
Supplemental Vision/Dental Coverage for Tribes	Agg	WW only	N/A	N/A	\$1,034,000	\$1,069,156	\$1,105,507	\$1,143,095	\$1,181,960
Designated State Health Programs	Agg	WW only	N/A	N/A	\$51,000,000	\$182,000,000	\$143,000,000	\$159,000,000	\$0

*PC – Per Capita; Agg – Aggregate

- 13.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could

have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

13.6. Hypothetical Budget Neutrality Tests.

- a. **Hypothetical Budget Neutrality Test 1: ACA Adults.** Table 11a identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11a. Hypothetical Budget Neutrality Test 1									
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
ACA Adults	PC	Both	\$709.82	5.5%	\$758.95	\$800.69	\$844.73	\$891.19	\$940.21

- b. **Hypothetical Budget Neutrality Test 2: YSHCN.** Table 11b identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11b. Hypothetical Budget Neutrality Test 2									
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
YSHCN	PC	Both	N/A	4.8%	\$0.00	\$752.60	\$788.73	\$826.59	\$866.27

- c. **Hypothetical Budget Neutrality Test 3: Continuous Eligibility.** Table 11c identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11c. Hypothetical Budget Neutrality Test 3									
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
CE PCR	PC	Both	\$715.99	5.2%	\$762.83	\$802.50	\$844.23	\$888.13	\$934.31
CE PWO	PC	Both	\$2,160.20	5.2%	\$2,301.51	\$2,421.19	\$2,547.09	\$2,679.54	\$2,818.88
CE CMO	PC	Both	\$482.05	5.0%	\$512.36	\$537.98	\$564.88	\$593.12	\$622.78
CE BCCP	PC	Both	\$2,273.78	5.2%	\$2,422.52	\$2,548.49	\$2,681.01	\$2,820.42	\$2,967.08
CE Old Age Assistance	PC	Both	\$700.37	4.3%	\$738.22	\$769.96	\$803.07	\$837.60	\$873.62
CE Aid to Blind/ Disabled	PC	Both	\$1,960.72	4.8%	\$2,079.06	\$2,178.85	\$2,283.43	\$2,393.03	\$2,507.90
CE Foster Children	PC	Both	\$802.34	5.0%	\$852.80	\$895.44	\$940.21	\$987.22	\$1,036.58

CE – Continuous Eligibility

- d. Hypothetical Budget Neutrality Test #4: MAGI Expanded Adult Program population. Table 11.d identifies the MEG that is used for Hypothetical Budget Neutrality Test 4. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11d. Hypothetical Budget Neutrality Test 4									
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
MAGI Expanded Adult Program	PC	Both	\$709.82	5.5%	\$758.95	\$800.69	\$844.73	\$891.19	\$940.21

- 13.7. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (as specified in STC 9), CMS considers these expenditures to be “capped hypothetical” expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state’s expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives (per STC 9.3); this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test’s expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent expenditure authority cannot roll over to the next demonstration approval

period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP provided under section 1115(a)(2) in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

- 13.8. **Capped Hypothetical Budget Neutrality Test: HRSN.** Table 12 identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 12. Capped Hypothetical Budget Neutrality Test							
MEG	PC or Agg	WOW Only, WW Only, or Both	DY21	DY22	DY23	DY24	DY25
HRSN services	Agg	Both	\$0M	\$223M	\$227M	\$227M	\$227M
HRSN Infrastructure	Agg	Both	\$51M	\$53M	\$5M	\$5M	\$5M

- 13.9. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 13.10. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from October 1, 2022 to September 30, 2027. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings, from up to 10 years of the immediately prior demonstration approval period(s) (July 1, 2012 to June 30, 2022). If at the end of the demonstration approval period

the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

- 13.11. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) The savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 13.10, or 2) 15 percent of the state’s projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state’s total Medicaid spending amount in its most recent year with completed data and trending it forward by the President’s Budget trend rate for this demonstration period. Fifteen percent of the state’s total projected Medicaid expenditures for this demonstration period is \$10,439,951,884.
- 13.12. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in Table 13 as a guide for determining when corrective action is required.

Table 13. Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	Cumulative Target Definition	Percentage
DY21	Cumulative budget neutrality limit plus:	2.0 percent
DY21 through DY22	Cumulative budget neutrality limit plus:	1.5 percent
DY21 through DY23	Cumulative budget neutrality limit plus:	1.0 percent
DY21 through DY24	Cumulative budget neutrality limit plus:	0.5 percent
DY21 through DY25	Cumulative budget neutrality limit plus:	0.0 percent

14. MONITORING ALLOTMENT NEUTRALITY

- 14.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:
- Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in section 2115 of the State Medicaid Manual.

- b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for the title XXI funded Medicaid expansion population (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and the title XXI funded separate CHIP population (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 and CMS-64.21U waiver forms for each title XXI demonstration population.
- c. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS-64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

- 14.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for the title XXI funded separate CHIP population and CMS-37 for the title XXI funded Medicaid expansion population. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the title XXI funded separate CHIP population and report demonstration expenditures for the title XXI funded Medicaid expansion population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS-64.21UP Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

- 14.3. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.
- 14.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 4 during the demonstration period.

Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

- 14.5. **Exhaustion of Title XXI Allotment for CHIP Populations.** If the state has exhausted title XXI funds, expenditures for the title XXI funded CHIP populations described in STC 4, and as approved within the CHIP state plan, may be claimed as title XIX expenditures. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the CHIP populations. The state shall report demonstration expenditures for these individuals, identified as population 4 in Attachment C, on the Forms CMS 64.9W and/or CMS 64.9P W.

15. EVALUATION OF THE DEMONSTRATION

- 15.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 11.1.
- 15.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.
- 15.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and

technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 15.7 and 15.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

- 15.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment O to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.
- 15.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes,

as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

Specifically, evaluation hypotheses for the HRSN initiatives must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. Hypotheses must be designed to help understand, in particular, the impacts of Oregon's housing support and food assistance programs on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the OHP demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing and nutrition supports change over time in concert with new Medicaid funding toward those HRSN services.

In addition, in light of how demonstration HRSN expenditures are being treated for budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

For the continuous eligibility policy, the state must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility. For example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes. The state must also evaluate the effectiveness of the continuous eligibility authority. For example, for the state's populations of focus under the

demonstration's continuous eligibility policy, to the extent feasible, the state may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the state may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing certain home-and-community-based services or services to address HRSN or behavioral health. Evaluation hypotheses must also address CCO's efforts to integrate behavioral, oral, and physical health, promote value-based care, and support cost-effective, quality health care to beneficiaries, and must further focus on the impact of passively enrolling FFS-eligible beneficiaries in CCOs.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must analyze the budgetary effects of the HRSN services, as well as the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the continuous eligibility and the HRSN demonstration components, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes,

and help inform how the demonstration's various policies might support reducing such disparities.

- 15.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.
- 15.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.
- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
 - b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.
 - c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.
 - d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

The Interim Evaluation Report must comply with Attachment B of these STCs.

- 15.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.
- a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS of the draft.

- b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within 30 calendar days.

- 15.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 15.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.
- 15.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.
- 15.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

16. SCHEDULE OF THE STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
No later than 90 days after demonstration approval	Approved DSHP List	STC 8.1
No later than 150 calendar days after demonstration approval	DSHP Claiming Protocol	STC 8.4
No required submission date; FFP for HRSN infrastructure and HRSN services is contingent on CMS	Protocols for HRSN Infrastructure and HRSN Services	STC 9.6

approval of these deliverables (separately)		
No later than nine months after demonstration approval	Draft New Initiatives Implementation Plan	STC 11.4
No later than 60 days after receipt of CMS comments	Revised New Initiatives Implementation Plan	STC 11.4
No later than 150 calendar days after demonstration approval	Draft Monitoring Protocol	STC 11.5
No later than 60 days after receipt of CMS comments	Revised Monitoring Protocol	STC 11.5
No less than six months prior to the expiration of the waiver of amount, duration, and scope related to the Prioritized List on December 31, 2026	Prioritized List Phase-out Plan	STC 11.8
No later than 120 calendar days after the expiration of the demonstration	Close-Out Report	STC 11.9
No later than 30 days after receipt of CMS comments	Revised Close-Out Report	STC 11.9
180 days after approval	Draft Evaluation Design	STC 15.3
No later than 60 days after receipt of CMS comments	Final Evaluation Design	STC 15.4
One year prior to current expiration date, September 30, 2027, or when the extension application is submitted, whichever is sooner	Draft Interim Evaluation Report	STC 15.7
No later than 60 days after receipt of CMS comments	Revised Interim Evaluation Report	STC 15.7
No later than 18 months after the end of the demonstration period (September 30, 2027)	Draft Summative Evaluation Report	STC 15.8
No later than 60 days after receipt of CMS comments	Revised Summative Evaluation Report	STC 15.8
<i>Annually</i>		
Annually (included in Annual Monitoring Reports)	State Quality Strategy	STC 5.8
No later than October 1 st and 90 days after the end of each DY thereafter	Annual Monitoring Reports	STC 11.6

No later than 6 months after the demonstration's implementation and annually thereafter	Post Award Forum	STC 11.11
<i>Quarterly</i>		
Quarterly	Quarterly Monitoring Reports	STC 11.6
Quarterly	CMS-64 Expenditure Reports	STCs 12-14

ATTACHMENT A

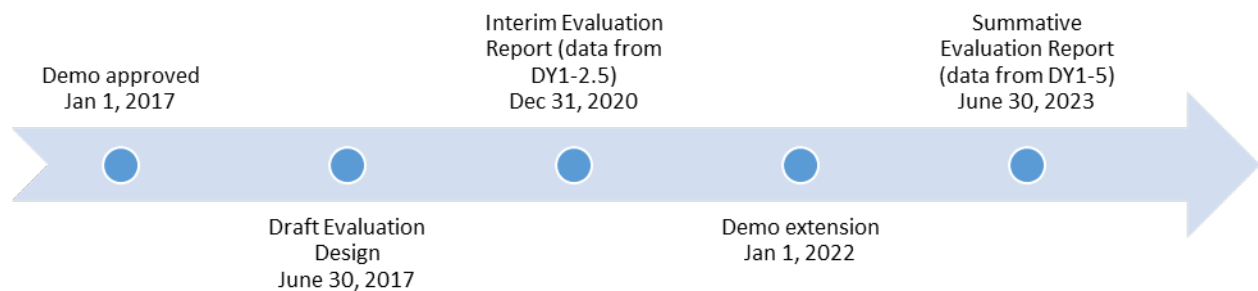
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations.

The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A.** General Background Information;
- B.** Evaluation Questions and Hypotheses;
- C.** Methodology;
- D.** Methodological Limitations;
- E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.
5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.
5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or

post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
 - a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).

- b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
 - c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
 - d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-

standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
 - a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
 - b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes;
 - b. No or minimal appeals and grievances;
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.
2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

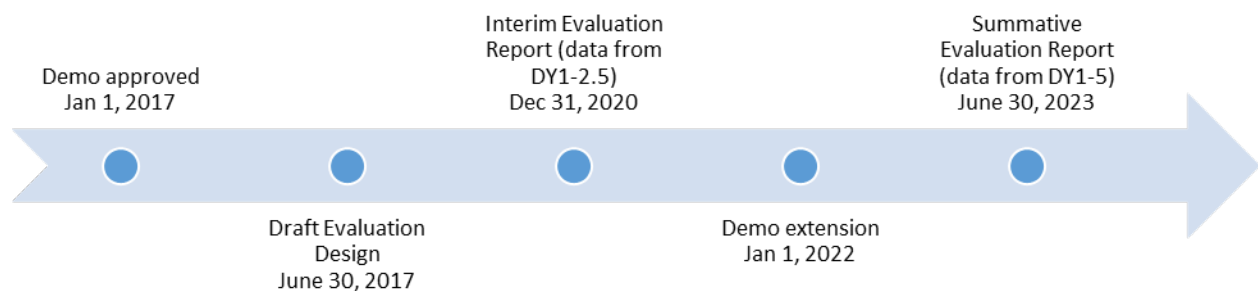
ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and,
- J. Attachment(s).

- A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
 3. A description of the population groups impacted by the demonstration.
 4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
 5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).
- C. **Evaluation Questions and Hypotheses** – In this section, the state should:
1. Identify the state’s hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
 2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
 3. Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
 4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
 2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.
 3. *Evaluation Period* – Describe the time periods for which data will be collected.
 4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
 5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
 6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
 7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.
- E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.
- F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.
- G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration

and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C
Summary Chart of Populations Affected by or Eligible Under the Demonstration

I. Mandatory Medicaid Populations							
Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
1	Pregnant Individuals	Title XIX	Title XIX state plan and section 1115	0% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL* Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1
4	Children 0 through 18	Title XXI	Title XXI state plan and section 1115	>133% up to 300% FPL	None	OHP Plus	Base 1
6	Medicaid mandatory section 1931 low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$2,500 for applicants, \$10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and section 1115; and those Dually	SSI Level	\$2,000 for a single individual, \$3,000 for a couple	OHP Plus	Base 2

			Eligible for Medicare and Medicaid				
8	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	\$2,000 single individual; \$3,000 for a couple	OHP Plus	Base 2
21	Uninsured or underinsured under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program (BCCTP)	Title XIX	Title XIX state plan and section 1115	Eligibility will be determined according to the state plan criteria.	None	OHP Plus	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX state plan and section 1115	0% up to 133% FPL	None	ABP (OHP Plus)	Base 2

*Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the state also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by federal regulations, since the state has chosen to extend Medicaid coverage to pregnant individuals up to 185 percent of the FPL.

II. Optional Medicaid Populations							
Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$2,000	OHP Plus	Base 2
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1

10	Youth with Special Health Care Needs (Youth transitioning to adulthood, age 19-26)	Title XIX	Title XIX state plan and section 1115	>133% to 300% FPL	None	OHP Plus	YSHCN
24	MAGI Expanded Adult Program	Section 1115	Section 1115	133% through 200% FPL	None	OHP Plus	MAGI Expanded Adult Program

ATTACHMENT D
Model Tribal Engagement and Collaboration Protocol
(reserved)

ATTACHMENT E
Coordinated Care Organizations Services Inventory
(reserved)

ATTACHMENT F
Approved DSHP List

(reserved)

ATTACHMENT G
DSHP Claiming Protocol

(reserved)

ATTACHMENT H
DSHP Sustainability Plan

(reserved)

ATTACHMENT J
Protocols for HRSN Infrastructure and HRSN Services
(reserved)

ATTACHMENT K
Oregon Provider Payment Rate Increase Assessment – Attestation Table
(reserved)

ATTACHMENT L
New Initiatives Implementation Plan
(reserved)

ATTACHMENT M
Monitoring Protocol

(reserved)

ATTACHMENT N
Prioritized List Phase-Out Plan
(reserved)

ATTACHMENT O
Evaluation Design

(reserved)

APPENDIX: Description of State Operations

1. **Health IT.** The CCOs are directed to use health IT and support the implementation and use of health IT to link services and providers across the continuum of care to the greatest extent possible. The CCOs are expected to support the achievement of minimum standards in foundational areas of health IT and to develop their own goals for transformational areas of health IT use.

- a. **Health IT:**

- i. CCOs must have plans for using health IT and supporting health IT adoption and use among contracted providers. This will include creating a pathway and/or a plan for adoption of health IT (using certified EHR technology when possible) and the ability to exchange data with and between providers outside their organizational and systems' boundaries to coordinate whole person care. If providers do not currently have this technology, there must be a plan in place for supporting adoption. CCOs' plans must also include support for community-based organizations to participate in capturing and exchanging social needs and services information using technology.
 - ii. OHA may monitor CCOs' capacity to leverage EHRs for quality, for example, in relation to the CCO quality incentive program and Value-Based Purchasing.
 - iii. The state will support communities' health IT infrastructure efforts in all regions (e.g., counties or other municipalities) to exchange health and social needs and services information.
 - iv. These state efforts and any requirements for CCOs must align with Oregon's state Medicaid health IT plans.

2. **Innovator Agents and Learning Collaboratives.** State shall utilize innovator agents to serve as an immediate line of communication between the CCO and the Oregon Health Authority. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the demonstration's goals of improving quality and access while managing costs, the state will:

- a. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.
 - b. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the state will plan and execute intensified technical assistance.

c. The information in (a) and (b) above will be incorporated into the CCO contracts.

3. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10, 42 CFR 438. 3(j) and 42 CFR 431.20, the state may allow the use of electronic methods for the beneficiary and provider communications as required by:

- 42 CFR 438.10(c) – Special rule for mandatory enrollment states – timeframes for providing information;
 - 42 CFR 438.10(e) – Information for potential enrollees;
 - 42 CFR 438.10(f)(2) and (3) – Right of enrollee to request and obtain information;
 - 42 CFR 438.10 (g)(2) and (3) – Information for enrollees-Enrollee handbook, Other plan information, including PIPs;
 - 42 CFR 438.10(h)(2), (3) and (4) – Information for enrollees-Provider directory, including PIPs;
 - 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
 - 42 CFR 438.102(b)(1)(i) and (ii) – state policies on excluded services.
- a. The state may allow the use of such electronic communications only if all of the following are met as required by 42 CFR 438.10(c)(6);
 - b. The format is readily accessible;
 - c. The information is placed in a location on the state or CCO’s website that is prominent and readily accessible;
 - d. The information is provided in an electronic form which can be electronically retained and printed;
 - e. The information is consistent with the content and language requirements of this section; and
 - f. The enrollee is informed that the information is available in paper form without charge upon request and provides it upon request within five (5) business days.

4. **Transparency/Public Reporting.**

- a. The state must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).

- b. The state shall publish data regarding CCOs' performance on state-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the state's progress toward achieving the primary goals of this demonstration.
- 5. **State Oversight of the CCOs.** The state Agency must have in effect a monitoring system for all managed care programs as required per 42 CFR 438.66 in its entirety, as well as ensure through contracts between the State and a CCO, the collection of encounter data as required by 42 CFR 438.242(4)(c).
- 6. **Additional Quality Measures and Reporting at the CCO Level.** The CCOs will be required to collect and validate data and report to the state on metrics as described in this section. CMS also encourages the CCOs to report on the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP.
 - a. **Metrics to track quality improvement.** The state will ensure the collection, analysis, and use of measures to drive quality improvement efforts for Medicaid and CHIP members which will be detailed in the state Medicaid Quality Strategy, inclusive of the quality measures and reporting at the CCO level.
 - b. **Core set of quality improvement measures.** The state will track measures to include Adult and Child Core Set measures (as updated annually), additional Consumer Assessment of Health Care Providers and Systems (CAHPS) or other member/patient experience of care measures, and upstream measures identified through public committee processes. In public reporting of these measures, the state will stratify by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography where possible.
 - c. **Access improvement measures based on CCO data.** The state and CMS identified and agree to additional access measures. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.
 - i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
 - ii. Percentage of adults with any outpatient visit.
 - iii. Percentage of adults with a chronic disease with any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
 - iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.

- v. Percentage of children with at least one dental visit.
 - vi. Fraction of physicians (by specialty) ‘participating’ in the Medicaid program.
 - vii. Change in the number of physicians (by specialty) participating in Medicaid.
 - viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
 - ix. Percentage of CCO enrollees with access to a PCPCH.
- d. **Access improvement measures based on state survey data.** The state will continue to field CAHPS or a similar member/patient experience survey to track access measures in the survey and will publicly report results.