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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 22-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

May 19, 2022

Patrick Allen, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number OR-22-0007

Dear Mr. Allen:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) OR-22-0007. This Alternative Benefit Plan amendment was submitted to comply the Consolidated Appropriations Act for 2021, which amended the Medicaid statute to add as a mandatory benefit, in both state plan and benchmark and benchmark equivalent coverage, for "routine patient costs for items and services furnished in connection with a qualifying clinical trial."

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 1905(a)(30), 1905(gg), 1902(a)(10)(A) and 1937(b)(5) of the Act. This letter is to inform you that OR-22-0007 was approved on May 19, 2022, with an effective date of January 1, 2022.

If there are any questions concerning this approval, please contact me or you may contact Maria Garza at maria.garza@cms.hhs.gov or at 206-615-2542.

Sincerely,

Digitally signed by James G. Scott -S
Date: 2022.05.19 18:06:38 -05'00'

James G. Scott, Director
Division of Program Operations

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Oregon**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

OR-22-0007

Proposed Effective Date

01/01/2022 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1905(a)(30), 1905(gg), 1902(a)(10)(A) and 1937(b)(5) of the Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2022	$ 0.00
Second Year	2023	$ 0.00

Subject of Amendment

This transmittal is being submitted to describe coverage for clinical trials under Section 210 of the Consolidated Appropriations Act, 2021. Although Oregon had previously adopted coverage based upon Medicare criteria several

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  The Governor does not wish to review any plan materials.

Signature of State Agency Official

Submitted By: **Jesse Anderson**

Last Revision Date: **Apr 26, 2022**

Submit Date: **Mar 31, 2022**

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New adult group: Program code AMO

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Voluntary	Remove

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The ABP is aligned with the current secretary approved OHP benefit package approved via the 1115 demonstration waiver. This benefit contains all 10 of the essential health benefits as well as additional categories not covered by the base benefit plan. The ABP meets or exceeds the base benchmark benefits.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

  Name of benefit package: Oregon Health Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ○ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

  Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: PacificSource Preferred CoDeduct Value 3000 35 70

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

It is Oregon's intention to provide the expansion population with the full set of Medicaid benefits provided to the State's categorically eligible population. This approach will help minimize disruptions for individuals who move among different benefit packages within The Oregon Health Plan. Under our 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) included on the states 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.
Oregon is proposing to use the PacificSource Preferred CoDeduct Value 3000 35 70 small group plan as the base benchmark plan for the ABP. This plan was also chosen by Oregon as the State's essential health benefits benchmark plan in the commercial market. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: OR - 22 - 0007

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

PacificSource Preferred CoDeduct Value 3000 35 70

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved.

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided: Physician services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Oregon utilizes a Patient Centered Primary Care type medical home model. The primary care provider is a gatekeeper for specialty care however, some services or procedures may require a prior authorization such as transplants; MRI; bariatric surgeries, etc

Benefit Provided: Nurse Practitioner

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Nurse Practitioners under state law function autonomously and generally follow a model similar to a Patient Centered Primary Care home. The primary care provider is a gatekeeper for specialty care however, some services or procedures may require a prior authorization such as transplants; MRI; bariatric surgeries, etc

Benefit Provided: Chiropractor (OLP)

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Family planning

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Podiatrist services (OLP)

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Optometrist

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Tobacco cessation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient hospital

Source: State Plan 1905(a)

Remove

Authorization: Yes

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: 90-day period with subsequent 60-day periods

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Certification of terminal illness required from physician, informed consent, etc. Concurrent care is provided to children, includes age 19 & 20.

Benefit Provided:

Source:

Remove

Authorization: None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Outpatient hospital services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency-Physician services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency medical transportation-outpatient hospit

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Hospital

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some procedures or services may require a prior authorization such as transplants; MRI; bariatric surgeries, etc. The Physician is responsible to obtain the authorization for the procedure.

Benefit Provided: Physician-inpatient services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some procedures or services may require a prior authorization such as transplants; MRI; bariatric surgeries, etc. The Physician is responsible to obtain the authorization for the procedure.

Add

Alternative Benefit Plan

☒ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided: Maternity care-Physician services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Maternity care-Nurse Practitioner
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Maternity care-Nurse Midwife services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Source:

Remove

Authorization:

Yes

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Benefit Provided: Inpatient hospital-MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These hospital services are provided in an acute care hospital and are not an IMD facility

Benefit Provided: Outpatient hospital-MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Most outpatient hospital services would not be rehabilitative or habilitative and would be acute situations taking them to an outpatient ED. Most rehabilitative or habilitative would be provided in residential facilities or office settings.

Benefit Provided: Physician services-MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Nurse Practitioner- MH/SUD
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Source:
Remove

Authorization: Yes
Provider Qualifications:

Amount Limit:
Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Inpatient hospital-Rehabilitative

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Rehabilitative-these hospital services are acute care hospitals and are not an IMD.

Benefit Provided: Physical, speech & occupational therapy-Rehab/Hab

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services and limits per plan of care, some services require authorization, limits can be exceeded when medically necessary.

Benefit Provided: Home health-Rehab/Hab

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:
Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Service authorization varies, this benefit includes DME, PT,OT, speech services provided in a home setting. Services and limits per plan of care, some services require authorization, limits can be exceeded when medically necessary.

Benefit Provided: Prosthetic devices-Rehab/Hab
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Some prosthetic devices require prior authorization. These include but are not limited to lumbar orthotics, spinal orthotics, orthopedic shoe, shoulder-elbow orthotics. Limits can be exceeded when medically necessary.

Benefit Provided: Eye glasses
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan

Amount Limit: Limits for non pregnant adults age 21 and over
Duration Limit: Limits for non pregnant adults age 21 and over

Scope Limit:
Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Limits to non-pregnant adults age 21 and over:
Routine vision services for the sole purpose of eyeglasses, are not covered. Coverage does include emergency eye exams and treatment and Non-emergency visual services with specific medical diagnoses.

Benefit Provided: Dentures
Source: State Plan 1905(a)
Remove

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits for age 21 and older

Duration Limit:
Limits for age 21 and older

Scope Limit:
Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Dentures are used to replace, correct, or support a full or partial set of teeth. For ages 21 and older, full dentures are limited to 1 every 10 years and partial dentures are limited to 1 every 5 years, exceptions are made when dentally appropriate.

Benefit Provided:
Nursing Facility services-Skilled

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Level of care needs

Duration Limit:
Level of care needs

Scope Limit:
Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Screening and assessment to determine level of care needs.

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services — Collapse All

Benefit Provided: Laboratory & X-ray

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management — Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services provided within the scope of practice as defined under state law

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary care to treat illness/injury

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary care to treat illness/injury were bundled, along with specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services and nurse practitioner services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Specialty visits

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialist visits were bundled, along with Primary care to treat illness/injury and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services and nurse practitioner services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient surgery were bundled, along with Primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Acupuncture

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Acupuncture services were bundled, along with Primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services and nurse practitioner services from the existing state Medicaid plan

Base Benchmark Benefit that was Substituted: Chiropractic

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chiropractic services were bundled, along with primary care to treat illness/injury and specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of chiropractic (OLP) services from the existing state Medicaid plan

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Naturopath

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Naturopathic services were bundled, along with Primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Chemotherapy services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chemotherapy services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Radiation therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Radiation therapy services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan

Base Benchmark Benefit that was Substituted: Sterilization

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Sterilization services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Home health care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care services were bundled, and mapped to the 'rehabilitative and habilitative services and devices'' EHB category. The bundled services are a duplication of Home Health-Rehab services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Telemedical services

Source: Base Benchmark

Remove

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Telemedical services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Care for disease of the eye

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Care for disease of the eye were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician and optometrist (OLP) services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Foot care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Foot care services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician and podiatrist (OLP) services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Medical contraceptives

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Medical contraceptives services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of family planning services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Emergency room-facility

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency room - facility services were bundled, along with emergency room visits and mapped to the 'emergency services' EHB category. The bundled services are a duplication of Emergency Hospital - Outpatient services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Emergency room-physician

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency room-physician services were bundled, along with primary care to treat illness/injury, specialist

Alternative Benefit Plan

visits and mapped to the 'emergency services' EHB category. The bundled services are a duplication of emergency-physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Emergency medical transportation

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency medical transportation were bundled, along with emergency room visits and mapped to the 'emergency services' EHB category. The bundled services are a duplication of Emergency medical transportation-Outpatient hospital from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Inpatient medical and surgical care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient medical and surgical care were bundled, along with inpatient hospital visits and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Bariatric surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Bariatric surgery services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Anesthesia

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Anesthesia services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital and physician-inpatient from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Breast reconstruction (non-cosmetic)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Breast reconstruction (non-cosmetic) services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital and physician-inpatient services from the existing state Medicaid plan.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Blood transfusion

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Blood transfusions services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital and physician-inpatient services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Hospice/respite care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice / respite care services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the ''Ambulatory patient services' EHB category. The bundled services are a duplication of hospice services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Pre & postnatal care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Pre- & postnatal care services were bundled, along with Maternity services and mapped to the 'maternity and newborn care' EHB category. The bundled services are a duplication of maternity care-physician, maternity care-nurse practitioner, nurse midwife services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Delivery & inpatient maternity services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & inpatient maternity services were bundled, along with Maternity services and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Inpatient hospital - mental/behavioral health

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient hospital - mental/behavioral health services were bundled, and mapped to the 'Mental Health and substanse use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Inpatient hospital-MH/SUD, physician-MH/SUD, nurse practitioner-MH/SUD, services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient hospital - mental/behavioral health

Source: Base Benchmark

Remove

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient hospital - mental/behavioral health services were bundled, and mapped to the 'Mental Health and substanse use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Outpatient hospital-MH/SUD, physician services-MH/SUD and nurse practitioner-MH/SUD services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Inpatient hospital - chemical dependency

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient hospital - chemical dependency services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Inpatient hospital-MH/SUD, physician services-MH/SUD and nurse practitioner-MH/SUD services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient hospital - chemical dependency

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient hospital - chemical dependency services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Outpatient hospital-MH/SUD, physician services-MH/SUD and nurse practitioner-MH/SUD services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Detoxification

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Detoxification services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of inpatient hospital, outpatient hospital, physician services and nurse practitioner services and the mental health and substance use disorder section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Inpatient rehabilitation

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient rehabilitation services were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of inpatient hospital, rehabilitative section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Physical, speech & occupational therapy

Source: Base Benchmark

Remove

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Physical, speech & occupational therapy (outpatient) services were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of Physical, speech & occupational therapy from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Durable medical equipment

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable medical equipment were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of home health-medical supplies from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Prosthetics

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prosthetics were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of prosthetic devices and home health-Rehab/Hab from the existing state Medicaid plan

Base Benchmark Benefit that was Substituted: Orthotics

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Orthotics were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of prosthetic devices and home health-Rehab/Hab from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Hearing aids

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hearing aids were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of physical, speech & occupational therapy, language disorders section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Cochlear Implants

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Cochlear Implants were bundled, and mapped to the 'Rehabilitative and habilitative services and devices'

Alternative Benefit Plan

EHB category. The bundled services are a duplication of prosthetic devices, physical, speech & occupational therapy, language disorders section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Lab tests, x-ray services, & pathology

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Lab tests, x-ray services, & pathology were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Imaging / diagnostics (e.g., MRI, CT ,PET scan)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Imaging / diagnostics (e.g., MRI, CT ,PET scan) were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Genetic testing

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Genetic testing services were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Preventive services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive care services were bundled, and mapped to the 'Preventive and wellness services and chronic disease management' EHB category. The bundled services are a duplication of Preventive services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Smoking/Tobacco cessation program

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Smoking/Tobacco cessation program were bundled, and mapped to the 'Ambulatory patient services' EHB category. The bundled services are a duplication of tobacco cessation sections from the existing state Medicaid plan

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Eyeglasses

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Eyeglasses were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of eyeglasses section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Dentures

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dentures were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of dentures section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Skilled nursing

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Skilled Nursings were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of Skilled Nursing Facility section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient hospital

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient hospital - facility services were bundled, and mapped to the 'Outpatient hospital' EHB category. The bundled services are a duplication of Hospital - Outpatient services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Organ & tissue transplants

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Organ & tissue transplants were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn child coverage

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit: Newborn services are billed separately through the newborn's Medicaid ID.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided: Dental

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Limits for age 21 and older

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Dental services for adults include the prevention and amelioration of dental disease states, limits on denture, crown, and periodontal coverage. Pregnant women receive some additional services.

Other 1937 Benefit Provided: Clinical services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other:

Other 1937 Benefit Provided: Targeted Case Management

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other:

Alternative Benefit Plan

Services provided within the scope of practice as defined under state law or Administrative rule. Targeted groups are HIV/AIDS, EI/ECSE, Babies First, Tribal members, Healthy Homes (Asthma), Children Who Are the Responsibility of Child Welfare, Self sufficiency and Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18.

Other 1937 Benefit Provided: Non emergency medical transportation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law or Administrative rule.

Other: NEMT provided through a brokerage system authorized under an 1115 waiver.

Other 1937 Benefit Provided: Private duty nursing services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Must meet the level of service criteria and nursing services must be medically appropriate and based on a physician's order.

Other 1937 Benefit Provided: Intermediate care facility services -ICF/IDD

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other:
Level of care assessment

Other 1937 Benefit Provided: Extended services for pregnant women

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other:
An initial needs assessment to assess the basic needs of the expectant mother and develop a client service plan (CSP) to optimize pregnancy outcomes. The program is referred to as the Maternity Case Management program.

Other 1937 Benefit Provided: Personal Care Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other:
Authorized based upon the plan of treatment or service plan. Personal Care Services include Activities of Daily Living (ADLs) as outlined in the Medicaid state plan.

Other 1937 Benefit Provided: Nursing Facility Services-Long Term

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit: Level of care need

Duration Limit: Level of care need

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Screening and assessment to determine level of care needs.

Other 1937 Benefit Provided: PACE

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Participants eligible for PACE are 55 or older, meet the state's criteria for long-term care eligibility with a service priority level of 1-13, and are Medicaid eligible.

Other 1937 Benefit Provided: Routine Patient Cost in Qualifying Clinical Trials

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Yes

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: See applicable Attachment 3.1-B & Attachment 4.19-B for coverage and reimbursement of Routine Costs in Qualifying Clinical Trials in Oregon's Medicaid State Plan.

Other 1937 Benefit Provided:

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☒ Prepaid Ambulatory Health Plans (PAHP).
- ☒ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

Individuals on the OHP Standard Reservation List were mailed a letter in September that explains how they may apply for Medicaid expansion benefits for January 1, 2014. The Authority is coordinating mailings to potential new eligbles prevent duplicate contacts. OHP Standard beneficiaries with a renewal date after December 31, 2013 will be converted to the Medicaid expansion program effective
January 1, 2014. An eligibility-related notice will be mailed explaining the new program; providing an overview of changes to the beneficiaries' benefit plan coverage and explaining reporting requirements. The notice will also be sent with information about managed care enrollment and benefit coverage. Notices for current clients in OHP Standard moving to OHP Plus inform them that they will qualify for OHP Plus services on 1/1/14. We explain that OHP Plus covers more services than OHP Standard and we list those services. We explain that their health plan and providers won't change and contact information is provided if they have questions.
Outreach included a letter to all affected clients in November 2013. We held a client focus group that reviewed the letter, created a fact sheet that is currently posted on the web. For providers we plan to mail a letter explaining the change, and revised OARs as needed. Information is/was shared with stakeholders at partner meetings and presentations and the Authority worked with the CCOs to coordinate member communications.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

Alternative Benefit Plan

◯ Section 1915(a) voluntary managed care program.

◯ Section 1915(b) managed care waiver.

◯ Section 1932(a) mandatory managed care state plan amendment.

◉ Section 1115 demonstration.

◯ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: July 5, 2012

Describe program below:

Oregon transitioned from using Fully Capitated Health Plans to Coordinated Care Organizations in 2013. As authorized under an 1115 waiver demonstration Oregon's delivery system has transitioned from using Managed Care Entities(MCE) known as Fully Capitated Health Plans, Dental Care Organizations and Mental Health Organizations to Coordinated Care Organizations beginning in August 2012. Initially, CCOs were required to provide both medical and behavioral health services (formerly provided under different MCEs). CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. CCOs are located throughout the state. OHA also transitioned Non-Emergent Medical Transportation (NEMT) from the 1915(b) waiver authority to the 1115 Demonstration for both coordinated care and fee-for-service OHP beneficiaries.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

◉ Competitive procurement method (RFP, RFA).

◯ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	Prescription drugs	Services not included in CCOs contract and reimbursed under FFS for those enrolled in CCOs include: Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents. a	Remove
Add	Hospice	Services not included in CCOs contract and reimbursed under FFS for those enrolled in CCOs include: Hospice services for Members who reside in a skilled Nursing Facility,	Remove
Add	Long term care	Services not included in CCOs contract and reimbursed under FFS for those enrolled in CCOs include: Long term care services	Remove

Alternative Benefit Plan

Add	abortions	Services not included in CCOs contract and reimbursed under FFS for those enrolled in CCOs include: herapeutic abortions (abortions comport with the Hyde amendment).	Remove

MCO service delivery is provided on less than a statewide basis. No

#type# Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: No

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

(●) Mandatory participation.

( ) Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

auto-assigned to a CCO through an auto-enrollment process. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled). Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment. Refere to Project Number 21-W-00013/10 and 11-W-00160/10) STC of Oregon's 1115 demonstration waiver.

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

( ) Section 1915(a) voluntary managed care program.

( ) Section 1915(b) managed care waiver.

(●) Section 1115 demonstration.

( ) Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: July 5, 2012

Describe program below:

Some regions of the state have a separate DCO enrollment outside of the CCOs. This will be going away as of 1/1/23 when all CCOs will provide dental care and we will no longer have a PAHP.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

Alternative Benefit Plan

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PAHP. Yes

List the benefits or services that will be provided apart from the #type#, and explain how they will be provided. Add as many rows as needed.

Add	Name	Description	Remove
Add	all benefits except dental	CCOs provide all MCO benefits as shown above with the exception of dental benefits that are included in a few DCOs in regions where the CCOs do not provide dental. These PAHP will be going away as of 1/1/23 when CCOs will include dental services in those regions.	Remove

PAHP service delivery is provided on less than a statewide basis. Yes

The limited geographic area where this service delivery system is available is as follows:

◉ PAHP service delivery is available only in designated counties.

○ PAHP service delivery is available only in designated regions.

○ PAHP service delivery is available only in designated cities and municipalities.

○ PAHP service delivery is available in some other geographic area (geographic area must not be smaller than a zip code).

Specify counties:

Currently there are 5 DCOs that serve members in the state. Some exclude certain zips codes but between these 5 all counties have DCO services.

#type# Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: No

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

auto-assigned to a CCO through an auto-enrollment process. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled). Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment. Refere to Project Number 21-W-00013/10 and 11-W-00160/10) STC of Oregon's 1115 demonstration waiver.

Additional Information: #type# (Optional)

Alternative Benefit Plan

Provide any additional details regarding this service delivery system (optional):

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. Yes

The managed care program is operating under (select one):

- ◯ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ◯ Section 1115 demonstration.
- ◯ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Jul 16, 2021

Describe program below:

This is an Indian Managed care Entity PCCM program. Refer to detail in TN21-0008

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

- ◯ Competitive procurement method (RFP, RFA).
- ◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

Indian Manage Care Entity for voluntary enrollment of American Indians Alaskan Natives. refer to details in TN 21-0008

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. No

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

- ◉ Per member/per month case management fee paid to PCCM provider.
- ◯ Other:

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

Alternative Benefit Plan

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(●) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The FFS program operates under an 1115 waiver demonstration as well as 1902(a) state plan coverage. Once determined eligible, an individual will be in FFS for a period of time. The majority of these individuals will be enrolled in a CCO within 2 weeks of determination. Populations that are not enrollable into a CCO would receive services through this FFS option such as Citizen/Alien-Waived Emergency Medical (CAWEM). OHA also transitioned Non-Emergent Medical Transportation (NEMT) from the 1915(b) waiver authority to the 1115 Demonstration for fee-for-service. Services not included in CCOs and reimbursed under FFS for those enrolled in CCOs include items such as: Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents, Hospice services for Members who reside in a skilled Nursing Facility, Long term care services and Therapeutic abortions (abortions comport with the Hyde amendment).

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

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V.20181119

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Employer Sponsored Insurance and Payment of Premiums	**ABP9**

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

For a Medicaid beneficiary who receives coverage in a health plan in the individual market through the state's approved Medicaid state plan that provides premium assistance under section 1905(a) and regulations codified at 42 CFR §435.1015, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits around the individual market health plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A."

The state/territory otherwise provides for payment of premiums. No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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V.20160722

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

State Name: Oregon

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: OR - 22 - 0007

Payment Methodology ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

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V.20160722