



*Administrator  
Washington, DC 20201*

OCT 15 2002

Mr. Hersh Crawford  
Administrator  
Department of Human Services  
Office of Medical Assistance Programs  
500 Summer Street, NE, 3<sup>rd</sup> Floor  
Salem, Oregon 94310-1014

Dear Mr. Crawford:

We are pleased to inform you that your application for a demonstration, entitled "Oregon Health Plan 2," as modified by the Special Terms and Conditions accompanying this award letter, has been approved as project No. 21-W-00013/10 and 11-W-00160/10. This approval will provide for coverage of the current mandatory Medicaid, optional and expansion populations included in the original Oregon Health Plan as well as provide for an expansion of coverage of targeted low-income children, parents of children eligible for Medicaid and the State Children's Health Insurance Program (SCHIP), pregnant women, and childless adults.

This demonstration is approved for a period of five years beginning with the implementation date as defined in section II.2. This approval is under the authority of section 1115 of the Social Security Act (the Act), and is a part of the Health Insurance Flexibility and Accountability (HIFA) initiative. Under HIFA, the Administration puts a particular emphasis on broad statewide coverage approaches like Oregon's that target Medicaid and SCHIP resources to populations with incomes below 200 percent of the Federal Poverty Level (FPL) seeking to maximize private health insurance coverage options.

Enclosed are the Special Terms and Conditions that define the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acceptance of the award, including the Special Terms and Conditions, within 30 days of the date of this letter.

All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the Oregon Health Plan 2 Demonstration.

### **Waivers**

This defines the Title XIX populations for which these waivers are granted. Demonstration Populations 1 through 8 and 9 have the option of choosing OHP Plus or the Family Health Insurance Assistance Program (FHIAP).

**Demonstration Population 1:** Medicaid mandatory pregnant women included in the State plan with incomes from 0 to 133 percent of the FPL who are in direct State coverage (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 2:** Medicaid optional pregnant women included in the State plan with incomes from 133 to 170 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals are considered optional and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 3:** Medicaid children 0 – 5 included in the State plan with incomes from 0 to 133 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 4:** Medicaid children 6 – 18 included in the State plan with incomes from 0 to 100 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 5:** Medicaid mandatory foster children (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 6:** Medicaid mandatory TANF Section 1931 low-income families (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 7:** Medicaid mandatory blind and disabled individuals with incomes at the SSI level of the FPL (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 8:** Medicaid mandatory elderly individuals with incomes at the SSI level of the FPL (as defined in the Special Terms and Conditions). *(These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*



6. Payment of Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) Section 1902(a)(10)

To enable the State to offer FQHC and RHC services only to the extent available through managed care providers.

7. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Section 1902(a)(43)(A)

To waive the requirement that states must pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefit package available to the individual.

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

To allow the state to not pay DSH payments when hospital services are furnished through managed care entities.

9. Medically Needy Program Section 1902(a)(10)(C)  
42 CFR 435.301, 435.811,  
435.845, 435.850-52 and  
440.220

To enable the State to discontinue the Medically Needy program under its State plan, except with respect to the aged, blind, and disabled populations.

10. Upper Payment Limit for Capitation Contracts Section 1902(a)(30)  
42 CFR 447.361

To enable the State to set capitation rates that would exceed the costs to Medicaid on a fee-for-service basis.

11. Benefit Package Requirements Section 2103  
42 CFR 457.410(b)(1)

To permit the State to offer a benefit package that does not meet the requirements of section 2103 and 42 CFR 457.410(b)(1). This approval is granted to the extent necessary to allow families of certain SCHIP children to elect to receive coverage for their children through a private or employer-sponsored insurance plan, which may not offer an SCHIP benefit package and may not offer well-baby and well-child care services and immunizations as defined by the State. This does not waive the provision of required

coverage of 42 CFR 457.410(b)(2) and (3) regarding age-appropriate immunizations and emergency services.

12. Cost Sharing Requirements

Section 2103(e)

To permit the State to impose cost sharing in excess of statutory limits. This approval is granted to the extent necessary to allow families of certain SCHIP children to elect to receive coverage for their children through a private or employer-sponsored insurance plan, which may require cost sharing in excess of the SCHIP limits.

**Medicaid Costs Not Otherwise Matchable**

Under the authority of section 1115(a)(2) of the Act, State expenditures under the Oregon Health Plan 2 demonstration described below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of the project, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditures, except those waived above and those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed Special Terms and Conditions will apply to these expenditure authorities.

**Demonstration Population 9:** General Assistance expansion individuals with incomes up to and including 43 percent of the FPL (as defined in the Special Terms and Conditions). *(These are individuals who would be considered expansion and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 10:** Expansion parents age 19 – 64 with incomes up to and including 100 percent of the FPL as of November 30, 2002 (as defined in the Special Terms and Conditions). *(These individuals are considered expansion and will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP if FHIAP is open and can extend coverage.)*

**Demonstration Population 11:** Expansion childless adults age 19 – 64 with incomes up to and including 100 percent of the FPL as of November 30, 2002 (as defined in the Special Terms and Conditions). *(These individuals are considered expansion and will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP if FHIAP is open and can extend coverage.)*

**Demonstration Population 12** Participants in the Family Health Insurance Assistance Program (FHIAP) with incomes up to 170 percent of the Federal poverty level as of September 30, 2002 (as defined in the Special Terms and Conditions). *(This would be the current state-funded FHIAP parents and childless adults who already have insurance, and the FHIAP children.)*

**Demonstration Population 13:** Pregnant women who are not eligible for Medicaid or Medicare with incomes from 170 to 185 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals are considered expansion and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

**Demonstration Population 14:** Participants who would have been eligible for Medicaid but choose FHIAP instead with incomes from 0 – 185 percent of FPL.

1. Costs of coverage to individuals that would otherwise be excluded by virtue of enrollment in managed care delivery systems that do not meet all requirements of section 1903(m). Specifically, Oregon managed care plans will be required to meet all requirements of section 1903(m), except the following:
  - 1903(m)(1)(A) and (2)(A); 42 CFR 434.20 and 21, insofar as they restrict payment to a state that contracts for comprehensive services on a prepaid or other risk basis, unless such contracts are with entities that:
    - a. meet Federal health maintenance organization (HMO) requirements or State HMO requirements;
    - b. allow Medicaid members to disenroll as set forth in section 1903(m)(2)(A)(vi). (The State will lock in enrollees for period of six months or more in FCHPs, PCOs, and PCCM organizations.)
2. Costs that might otherwise be disallowed under section 1903(f); 42 CFR 435.301 and 435.811, insofar as they restrict payment to a state for eligibles whose income is no more than 133 1/3 of the AFDC eligibility level.
3. Costs of Medicaid to individuals who have been guaranteed six months of Medicaid eligibility at the time they are enrolled in a capitated health plan, who were eligible for Medicaid when they were enrolled, and who ceased to be eligible during the 6 month period to OHP Standard demonstration participants and 12 months of guaranteed eligibility to FHIAP enrollees.

4. Costs of chemical dependency treatment services 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.
5. Costs for capitation payments provided to managed care organizations which restrict enrollees' right to disenroll in the initial 90 days of enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A).
6. Costs for services provided to OHP-eligible individuals between the ages of 22 and 65 who are institutionalized for mental diseases. This exception is limited to short-term (less than 30 days) inpatient mental health care for persons in the Eastern Oregon Psychiatric Center.
7. Costs for certain mandatory and optional Medicaid eligibles to elect to receive coverage through a private or employer-sponsored insurance plan. Such enrollment in a plan that offers a limited array of services or in a private or employer-sponsored plan is voluntary and the family may elect to switch, if eligible, to direct state coverage at any time, and families will be fully informed of the implications of choosing FHIAP rather than direct State coverage.

**Medicaid Requirements not Applicable to the Medicaid Expenditure Authorities:**

All Medicaid requirements apply, except as waived above for the State plan population and services, except to the following:

**Cost Sharing, Section 1902(a)(14).**

For the time period during which an eligible individual elects to receive coverage through a private or employer-sponsored insurance plan, these requirements do not apply, to the extent a private or employer plan would require cost sharing in excess of the limits outlined in statute.

**Retroactive Coverage, Section 1902(a)(34).**

For FHIAP participants, no retroactive payments will be made.

**SCHIP Costs Not Otherwise Matchable**

In addition, also under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2106(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under title XXI), shall for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of the title XXI statute will be applicable to such expenditures, except those waived above and those specified

below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed Special Terms and Conditions will apply to these expenditure authorities.

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**Demonstration Population 15:** Uninsured children with incomes from 170 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who meet the title XXI definition of a targeted low-income child and are enrolled in direct State coverage.

**Demonstration Population 16:** Uninsured children ages 0 – 5 with incomes from 133 to 185 percent of the FPL and uninsured children ages 6 – 18 with incomes from 100 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who meet the title XXI definition of a targeted low-income child and choose voluntary enrollment in FHIAP.

**Demonstration Population 17:** Uninsured parents of children who are eligible for Medicaid or SCHIP, who are themselves ineligible for Medicaid/Medicare with incomes from 0 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who are enrolled in either OHP Standard or FHIAP.

**Demonstration Population 18:** Uninsured childless adults who are not eligible for Medicaid/Medicare with incomes from 0 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who are enrolled in either OHP Standard or FHIAP.

**SCHIP Requirements Not Applicable to the SCHIP Expenditure Authorities:**

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

Rules governing cost sharing under section 2103(e) shall not apply to the demonstration populations to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored insurance plans for Demonstration Populations 16 through 18.

**2. Benefit Package Requirements-Section 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103 of 42 CFR 457.410(b)(1) for demonstration populations 16 through 18.

**3. General Requirements, Eligibility and Outreach- Section 2102**

Applicants for the demonstration will be screened for Medicaid and SCHIP eligibility. Applicants will be offered an informed choice of voluntary enrollment in the direct coverage program for which they may be eligible or in FHIAP if it is available. During the demonstration project, eligibility status of enrollees will be redetermined on a regular basis. Payment for the FHIAP enrollees will be based on the program for which they could have been eligible.

**4. Restrictions of Coverage and Eligibility to Targeted Low-Income Children -Sections 2102 and 2110**

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

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### **5. Federal Matching Payment and Family Coverage Limits-Section 2105**

Federal matching payment is available in excess of the ten-percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable with respect to the demonstration populations. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

### **6. Annual Reporting Requirements Section 2108**

Annual reporting requirements do not apply to the demonstration populations, with the exception of demonstration populations 15 and 16.

We are granting the new expenditure authorities listed above to demonstrate whether expanding eligibility for coverage of parents of Medicaid and SCHIP children, and the demonstration populations listed above, will improve the overall health of the community, and reduce overall rates of uninsurance. This result would promote the objectives of the Act.

The State will establish a process to ensure that demonstration expenditures do not exceed the state's available title XXI funding. To ensure the availability of the SCHIP allotment for the primary beneficiaries of title XXI, title XXI funding will be used to provide coverage in the following order:

- first to children eligible under the title XXI State plan,
- children eligible as demonstration population 15 and demonstration population 16, then for demonstration population 17,
- and, then for demonstration population 18.

Title XXI funding will first be used to cover those groups listed in the priority order above, then if title XXI funding has been depleted, the state will establish a process to ensure that demonstration expenditures will revert to title XIX.

### **Additional Information**

Included as part of this award is the authority to implement the OHP2 program with a single managed care plan in urban areas. The State is required to continue its efforts to increase plan participation in the Oregon Health Plan 2. In addition, the state will permit beneficiaries to obtain services outside of the network consistent with treatment of enrollees in plans in rural areas.

You have also requested a streamlined process for approval of revisions to the current Prioritized List of Health Care Services currently funded through line 566. CMS will continue to work with the state to develop a streamlined process for review and approval of revisions to the benefit packages for OHP2 enrollees.

In addition, currently the State receives Federal match for expenditures for providing mental health and chemical dependency services to Medicaid enrollees between the ages of 22 and 65 residing in the Eastern Oregon Psychiatric Center Institutions for Mental Disease (IMD) facility. You requested that we provide additional expenditure authority to allow for one additional IMD facility, and the flexibility to allow for additional facilities as necessary. I regret to inform you that no additional expenditure authority will be permitted. Furthermore, under the new demonstration, we are requiring a phase-out of this program by allowing Federal financial participation for 100 percent of qualifying expenditures for the first 3 years, 50 percent for year four and none in year five.

You also requested Federal match for expenditures for providing children served in the Intensive Treatment Services program with a 6-month Medicaid expansion of eligibility window for transition services from residential psychiatric facilities into their family homes. We are not granting the expenditure authority requested.

Congratulations on the approval of your innovative approach to expanding health insurance coverage. Your project officer is Ms. Donna Schmidt. Ms. Schmidt is available to answer any questions concerning implementation of your section 1115 demonstration and can be reached at (410) 786-5532. Her address is:

Centers for Medicare & Medicaid Services  
Center for Medicaid and State Operations  
Mail Stop S2-01-16  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850  
Email: [Dschmidt@cms.hhs.gov](mailto:Dschmidt@cms.hhs.gov)

Official communications regarding program matters should be sent simultaneously to the project officer and to Ms. Bunnee A. Butterfield, Acting Associate Regional Administrator for the Division of Medicaid and State Operations in the Seattle Regional Office. The address is:

Centers for Medicare & Medicaid Services  
Region X  
2201 Sixth Avenue, MS/RX-40  
Seattle, Washington 98121-2500  
Email: [Bbutterfield@cms.hhs.gov](mailto:Bbutterfield@cms.hhs.gov)

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We look forward to continuing working with you and your staff.

Sincerely,

Thomas A. Scully

Enclosure