STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (CHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Oregon
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Judy Mohr Peterson	Position/Title: Administrator Division of Medical Assistance
Name:	Position/Title:
Name:	Position/Title:

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 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C.

20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☒ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☐ A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))
The Division of Medical Assistance Programs (DMAP) assures that expenditures for this program will not be claimed prior to the time the State has legislative authority to operate the State plan or plan amendment as approved by CMS.

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)
DMAP assures that the state complies with all applicable civil rights requirements, including those listed above.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: **July 1, 1998**

Implementation date**: July 1, 1998**

State Plan Amendment #2: Minor revisions to performance measures in approved XXI State Plan
Submitted: May 30, 2000
CMS Approved: September 11, 2000

State Plan Amendment #3: Increase enrollment cap to 19,800
Submitted: December 12, 2000
CMS Approved: March 9, 2001

State Plan Amendment #4 Compliance with final CHIP regulations and updated program descriptions
Submitted: July 31, 2002
CMS Approved: April 15, 2003

State Plan Amendment #5: Asset limit increase to $10,000
Submitted: August 19, 2004
CMS Approved: November 10, 2004
Effective date: October 1, 2004

State Plan Amendment #6: Duration of eligibility period increased to 12 months
Submitted: May 16, 2006
CMS Approved: August 1, 2006
Effective Date: June 1, 2006

State Plan Amendment # 7: Unborn child expansion
Submitted: July 31, 2007
Approved: April 9, 2008
Effective: April 1, 2008

State Plan Amendment #8: Require SSN on application
Submitted: September 13, 2007
Approved: December 12, 2007
Effective: October 1, 2007

State Plan Amendment # 9: Transition the following targeted low income children from Section 1115 demonstration to the state plan: children ages 0 through 18 above 170 percent of the FPL up to 185 percent of the FPL.
Submitted: November 30, 2007
Approved: September 16, 2008Effective: November 1, 2007
State Plan Amendment # 10: This amendment expands the income

Deleted: 7¶

eligibility level for CHIP children through age 18 from 185 percent of the Federal poverty level (FPL) up to and including 300 percent of the FPL under the State's Healthy Kids initiative. This SPA is a companion amendment to the State's section 1115 title XXI demonstration amendment. This SPA also creates a new private insurance option, referred to as Healthy KidsConnect, specifically for children from 200 up to and including 300 percent of the FPL under Secretary-approved coverage under the CHIP state plan. In addition, this SPA institutes an Application Assistance Program to assist families applying for CHIP and other child health programs in the State as part of its Healthy Kids initiative, finances an outreach and enrollment grant program designed to provide culturally-specific and targeted outreach and direct application assistance to families in racial, ethnic and language minority communities living in geographic isolation or with additional access barriers, reduces the waiting period of uninsurance for CHIP coverage from 6 months to 2 months, and eliminates the asset test in CHIP This amendment will have a retroactive effective date of October 1, 2009, for the expansion of eligibility from 185 percent of FPL up to and including 200 percent of the FPL, as well as for the application assistance program, outreach and enrollment grant program, the waiting period reduction, and elimination of the asset test.
Submitted: July 27, 2009
Effective: October 1, 2009
This amendment will also have an effective date of January 1, 2010, for the expansion of eligibility above 200 percent of the FPL up to and including 300 percent of the FPL. However, the State must receive approval for its section 1115 demonstration amendment in order to permit children to enroll in its premium assistance programs.
Submitted: July 27, 2009
Approved: December 18, 2009
Effective: January 1, 2010.

State Plan Amendment #11: Expand Unborn population coverage to Benton, Clackamas, Hood River, Jackson and Lincoln counties.
Submitted: August 26, 2009
Effective: October 1, 2009
This amendment also closes the expansion in Lincoln County effective December 31, 2009.
Submitted: December 22, 2009
Approved: September 20, 2010
Effective: January 1, 2009

State Plan Amendment # 12: CHIPRA provisions related to those who have not met the 5 year waiting period for immigrant children.
Submitted: July 27, 2009
Approved: May 18, 2010
Effective: October 1, 2009

State Plan Amendment # 13: Designate express lane eligibility agencies as the Supplemental Nutritional Assistance Program (SNAP) and selected Department of Education, National School Lunch Program (NSLP).
Submitted: August 9, 2010
Approved: October 21, 2010
Effective: August 1, 2010

State Plan Amendment #14: Expand Unborn population coverage to Lane county.
Submitted: October 11, 2010
Effective: January 1, 2011
This Amendment also revises the budget month used for income Eligibility
Approved:
Effective: November 1, 2010

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Prior to implementation of CHIP in 1998, approximately 870,000 children in the state of Oregon were under the age of 19. About 92 percent of them, 800,000, had health insurance coverage of some form. Children of Hispanic or racial minority origin are more likely than their Caucasian counterparts to be uninsured. Fourteen percent of Hispanic children and 9 percent of other minority children are uninsured, compared with only 7 percent of Caucasian children. Most uninsured children live in households earning less than $25,000 per year, while median household income for all children in the state is more than $40,000 per year.

The economic conditions of the state and nation reflect an increase in the number of uninsured. The 2006 Oregon Population Survey (OPS) shows 12.6% of children under age 19 lacked health insurance coverage last year compared to 13% in 2004 and 10.6% in 2002.
The table below compares number of uninsured children by Federal Poverty Level (FPL).

	<100%	100-135%	135-150%	150-185%	186-200%	>200%
Age 0-4 Total	35,817	13,567	9,226	15,195	11,668	148,695
Age 0-4 insured	32,021	12,129	8,248	13,584	10,431	132,934
Age 0-4 uninsured	3,797	1,438	978	1,611	1,237	15,762
Age 5-9 Total	37,076	14,044	9,550	15,729	12,078	153,923
Age 5-9 insured	33,146	12,555	8,538	14,062	10,798	137,608

	<100%	100-135%	135-150%	150-185%	186-200%	>200%
Age 5-9 uninsured	3,930	1,489	1,012	1,667	1,280	16,316
Age 10-14 Total	38,818	14,704	9,999	16,468	12,645	161,155
Age 10-14 insured	34,704	13,145	8,939	14,723	11,305	144,073
Age 10-14 Uninsured	4,115	1,559	1,060	1,746	1,340	17,082
Age 15-17 Total	23,556	8,923	6,067	9,993	7,673	97,792
Age 15-17 insured	21,059	7,977	5,424	8,934	6,860	87,426
Age 15-17 Uninsured	2,497	946	643	1,059	813	10,366

Sources: Population Research Center, Portland State University data for July 2008, Bureau of Labor Statistics/ U.S. Census; Current Population Survey (CPS)

The primary source of health coverage for most children is an employer-based policy, most often sponsored by a parent's employer. In 1998 Employer-based coverage accounted for 82 percent of all children's health insurance coverage in the state, while public sources made up 13 percent and the remaining 5 percent was from other sources. In 2007 Employer-based coverage decreased as the unemployment rate increased.

During Oregon's 2009 Legislative Session, HB 2116 created the Healthy Kids initiative. Healthy Kids provides coverage for uninsured children through age 18 in the State. The objective of Healthy Kids is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. HB 2116 increases the FPL from 185 percent of FPL up to and including 300 percent of FPL for children. Healthy Kids includes three different program components: 1) Existing CHIP direct coverage under OHP Plus, 2) Child only premium assistance administered by the Office of Private Health Partnerships, and 3) A new private insurance component (Healthy KidsConnect) that will be offered under the CHIP State Plan.
CHIP-eligible children that select direct coverage or Healthy KidsConnect under the CHIP state plan are governed by the title XXI state plan and subject to all title XXI laws and regulations in accordance with the title XXI State plan. Children that select FHIAP or child-only Healthy Kids ESI premium assistance under the demonstration are subject to all title XXI laws and regulations in accordance with the State plan, except as expressly waived, described as non applicable, or specified in the OHP 1115 waiver demonstration STCs. Children up to and including 200 percent of the FPL have the choice between Title XXI state plan direct coverage, or premium

assistance through FHIAP or Healthy Kids ESI. Children in families over 200 percent up to and including 300 percent of the FPL have the choice between child only premium assistance under Healthy Kids ESI, or Healthy KidsConnect coverage under the CHIP state plan.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

As part of the outreach effort, the Office of Private Health Partnerships and the Department of Human Services plan to conduct a number of training sessions across the state. These training sessions focus on getting timely and accurate information about Healthy Kids into the hands of local community partners who have extensive contact with clients. Activities will target children eligible as the result of covering higher income levels, but also attempt to reach children at lower income levels who are eligible for but not enrolled in current programs. The Department of Human Services will develop and distribute educational materials for parents that focus on the importance of obtaining health coverage for their children and receiving preventive services

Children from birth to age 6 with family incomes less than 133% of the federal poverty level (FPL) and children 6-18 with family incomes up to 100% of the FPL are eligible for coverage under the Oregon Health Plan Medicaid Demonstration.

OHP Medicaid and CHIP applications and application assistance are available at the 64 DHS Children, Adults and Families Division (CAF) branch offices throughout the state and at 56 Senior and Disabled Services field offices. A well-publicized 800 number to the OHP Medicaid/CHIP Application Center is also available. The Application Center mails applications on request and helps callers in completing OHP applications and related forms. Applications may also be obtained and submitted on line via the Internet, through outreach locations at FQHCs, Tribal health clinics, DSH hospitals, Healthy Start, local health departments and Certified Application Assistance Organizations. Brochures outlining the services and eligibility requirements and containing the Application Center toll-free number and Web address are widely available in provider offices, libraries and other community

distribution points throughout the state. The toll-free number for the Application Center also appears in the white pages of telephone directories throughout the state. Information about OHP Medicaid/CHIP services, eligibility requirements and processes is also available on the DMAP website.

Express Lane Eligibility:
The Department utilizes designated agencies (SNAP and NSLP) in order to provide a simplified eligibility determination process and expedited enrollment of eligible children in Medicaid and CHIP.

VISTA Health Links Project
VISTA volunteers work in many counties throughout the state. As a part of their activities to ensure public health systems and programs work well together for the women and children they serve, these volunteers provide clients assistance and information on the Oregon Health Plan, immunizations, prenatal care and other health issues/concerns. The WIC program has the broadest client base of the VISTA Health Links partner programs, and is often the gateway service for women and children. Therefore, a good deal of the VISTA Health Links Project focus is around developing outreach efforts and systems to promote immunizations, OHP registration and early prenatal care access among WIC clients.

Community-Based Application Assistance Project
This program, started in January 1998, allows local health departments, Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC) and Tribal Health Clinics to distribute OHP Medicaid/CHIP applications and to give on-site assistance with completion of the OHP application for children, pregnant women and their families. Currently DMAP has 200 outreach sites located throughout the state.

Hospital Hold-CHIP OHP Plus
If an uninsured patient is admitted to a hospital, the hospital may fax a Hospital Hold form for the patient to the OHP Medicaid/CHIP Application Center within 24 hours of the admission, or by the next working day. The intent of this program is to allow people who receive care in a hospital (inpatient only) to secure a date of request for the Medicaid/CHIP program application although they cannot physically reach a phone or a DHS branch. An OHP Medicaid/CHIP application is sent to the patient. For those who complete and return the application and are determined eligible for OHP Medicaid or CHIP, their eligibility is retroactive to the

date of request. The original date of request is honored if the application is received within 45 days from the date of request.

SAFENET
SAFENET is a community partnership program that provides a statewide toll free information/referral phone line for Oregonians. It is the state's Maternal and Child Health (MCH) hotline, designed to link low-income Oregon residents with health care services within their communities, including information on the Oregon Health Plan.

OFFICE OF PRIVATE HEALTH PARTNERSHIPS (OPHP) – INFORMATION, EDUCATION AND OUTREACH (IEO)
OPHP's statutory mission is to increase access to health insurance and health care by providing, in part, a central source for information about resources for health care and health insurance. The program trains insurance agents, consumers, and agency partners on state and federal regulatory changes and reforms, as well as in-depth information on the programs of the Oregon Health Plan. Training also includes information about non-traditional and non-insurance based health care resources, such as rural or safety net clinics and public health departments. Applicants to the Family Health Insurance Assistance Program also receive informational materials about the Oregon Health Plan Medicaid and CHIP programs.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

- **Family Health Insurance Assistance Program (FHIAP) for Families Enrolled in ESI or Individual Market: The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.**

    - **FHIAP and Healthy Kids ESI Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL: Subsidies are available to children in this income category through FHIAP or Healthy Kids ESI. Children who are determined eligible for HK ESI by DHS are referred to OPHP for enrollment and subsidy payment. These families with children can also go directly to OPHP to apply for**

FHIAP premium assistance for the whole family. If this option is chosen, these children are put on the FHIAP reservation list. Families are encouraged to apply for immediate coverage through Healthy Kids ESI or direct coverage under the CHIP state plan. FHIAP premium subsidies range from 50 to 95 percent for adults and 100 percent of the premium for children in this income group. Healthy Kids ESI subsidies are 100 percent for children in this income group. Individuals (adults and children) who enroll in FHIAP are subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP, Healthy Kids ESI or CHIP direct coverage (OHP Plus). Children enrolled who choose FHIAP or Healthy Kids ESI can move to State plan direct coverage at any time.

- **Healthy Kids ESI Premium Assistance for children in families with incomes above 200 up to and including 300 percent of FPL. Children in families with incomes above 200 percent FPL are not eligible for CHIP OHP Plus. Subsidies are available to children in this income category through Healthy Kids ESI. Sliding scale subsidies are available for children who are able to enroll in the family's ESI.**
  - **Families with incomes above 200 up to and including 250 percent of FPL will pay a maximum of 10 percent of the child's monthly premium.**
  - **Families with incomes above 250 up to and including 300 percent of the FPL will pay a maximum of 15 percent of the child's monthly premium.**
  - **All other cost-sharing is subject to the cost of the employer plan.**

- **Healthy KidsConnect: This is a private insurance option available to children under the CHIP state plan. Sliding scale subsidies are available to children who enroll in State-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package. Children in families with incomes above 200 percent FPL are not eligible for CHIP OHP Plus.**
  - **Families with incomes above 200 up to and including 250 percent of FPL will pay a maximum of 10 percent of the child's monthly premium; and**
  - **Families with incomes above 250 and 300 percent of the FPL will pay a maximum of 15 percent of the child's monthly premium.**

- **Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.**

Another component of the overall Oregon Health Plan is the Oregon Medical Insurance Pool (OMIP), Oregon's high risk health insurance program. The program provides health insurance to Oregon children and their families who have been denied health insurance due to health conditions. OMIP also provides a way to continue coverage for those who exhaust COBRA benefits with no other options. As of May 2009 OMIP serves approximately 15,500 individuals.

The Information, Education, and Outreach program and FHIAP marketing staff connect employers and individual consumers with OPHP-trained agents for help in purchasing a health insurance plan. Agents across the state are trained by staff on the latest state and federal regulatory changes and commercial health insurance reforms, in addition to in-depth information on the programs of the Oregon Health Plan. Marketing staff meet with employers across the state to promote employer partnerships to reduce the overall rate of uninsured in the state.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))
Oregon conducts the following activities to coordinate the Title V Maternal Child Health Program with OHP-CHIP:

The Child Development and Rehabilitation Center (CDRC) administers the Oregon Services to Children with Special Health Needs (OSCSHN) Title V Program at the Oregon Health and Sciences University (OHSU). The OSCSHN Financial Assistance Program provides financial assistance to families who meet the financial eligibility criteria at three times the federal poverty level and whose child has a qualifying medical diagnosis. Financial counselors screen families to determine program eligibility and make referrals to OHP including Medicaid, CHIP and the Family Health Insurance Assistance Program (FHIAP) when appropriate. OSCSHN staff, conduct follow-up calls to families referred to the OHP to determine the status of applications and to provide assistance when needed. This effort has resulted in more families qualifying for benefits and cost savings to the OSCSHN budget.

The DHS Public Health Division, Office of Family Health Services (OFHS) serves as the state Title V Agency and continues to work closely with DMAP. The OFHS maintains an agreement with DMAP for a community immunization program and to purchase vaccines for children enrolled in CHIP, for joint management of the Section 1115 Demonstration Family Planning Expansion Project, and for the MCH Hotline, SafeNet, which is contracted to the Multnomah County Health Department. Other coordination efforts include lead screening, preschool and adolescent immunization, vaccines for children, school based health centers, Oregon MothersCare, Babies First and CaCoon.

FHIAP: Applicants to the FHIAP program also receive informational materials that include the toll free telephone number for the application center and other materials about the Oregon Health Plan Medicaid and CHIP programs.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))
CHIP OHP Plus coverage: Health care services for CHIP clients are primarily provided through the managed care delivery system already established for the OHP Medicaid Demonstration. The managed care delivery system consists of prepaid health plans (PHPs) and primary care case managers (PCCMs) that manage the care of CHIP enrollees for a monthly capitated payment. The Division of Medical Assistance Programs (DMAP), within Oregon's Department of Human Services (DHS), manages the Medicaid Demonstration Project, and has primary responsibility for operation of S-CHIP. The State of Oregon contracts with fourteen Fully Capitated Health Plans (FCHPs), one Physician Care Organization (PCO), nine Dental Care Organizations (DCOs), and nine Mental Health Organizations (MHOs). Oregon also contracts with one Chemical Dependency Organization (CDO) in Deschutes County (in all other counties, chemical dependency services are provided through the Fully Capitated Health Plans or on a fee-for-service basis). As part of OHP Medicaid and CHIP policy all plans are encouraged to incorporate safety net providers in their delivery system and most FQHCs, rural health clinics and local health departments that provide primary care are incorporated into plan networks.

CHIP enrollees have the same choice of managed care plans as OHP Medicaid enrollees in their area. CHIP clients are required to enroll in a FCHP or a PCO, and a DCO, a MHO, and, in Deschutes County only, a CDO, as a condition of eligibility. If no managed care plan is available, the CHIP client may select a PCCM from a list of available PCCMs in their service area and will receive health services on a managed fee-for-service (FFS) basis. DMAP monitors plan provider capacity quarterly and we track enrollment monthly. If it is determined that there is insufficient capacity in a geographic area, CHIP clients are not required to enroll in a managed care plan and may receive services on a fee for service basis. In service areas where DCO capacity is limited, CHIP clients are not

required to enroll in a DCO and can receive dental services on a FFS basis from any dentist enrolled with DMAP who will accept their CHIP insurance. The problem of dental care capacity in Oregon, and particularly pediatric dental capacity, is not unique to Oregon Medicaid. There is overall an insufficient supply of pediatric dentists in the state. DMAP continues to work in coordination with the Oregon Dental Association and Dental coalitions to develop strategies to encourage more dentists to practice in Oregon.

FHIAP Program:

The Office of Private Health Partnerships (OPHP) administers FHIAP; a premium assistance program for families from zero up to and including 200 percent FPL who are enrolled in ESI or Individual private market health plans. FHIAP provides subsidies to program participants to purchase Employer Sponsored Insurance Plans (ESI) or individual market plans. Insurance plans approved for subsidy must meet benefit benchmark standards.

Healthy Kids ESI:

OPHP also administers Healthy Kids ESI; a private insurance option available to children in families who have employer-sponsored insurance available to them. Healthy Kids ESI subsidies are available to children in families from zero up to and including 300 percent of the FPL. HK ESI plans must meet the same benchmark standards as FHIAP plans.

The benchmark for FHIAP and Healthy Kids ESI plans is approved at a level actuarially equivalent to federally mandated Medicaid benefits (as outlined in CMS approval letter, #21-W-00013/10 and 11-W-00160/10). FHIAP requires all eligible children of enrolled families insured, in order for adults to receive assistance. All eligible children in the household must be insured through public or private coverage first, and the coverage must be maintained as long as the family is enrolled. FHIAP and Healthy Kids ESI carriers are licensed and regulated by the Oregon Insurance Division. They must adhere to rules and regulations specific to commercial insurers, the plans offered by these carriers must meet the benchmark requirement. The benefits must meet a federally-approved benchmark (as outlined in CMS approval letter (#21-W-00013/10 and 11-W-00160/10). FHIAP and Healthy Kids ESI is a "qualifying event", so members generally have an opportunity to enroll in their health plan immediately, without waiting for open enrollment. Eligible members also have the opportunity to enroll in OHP-Plus if they

are not able to obtain health benefits through their group plan immediately, and they meet the eligibility requirements for the Medical Assistance Program or CHIP. Children with income above 200% FPL have the opportunity to enroll in Healthy KidsConnect.

Healthy KidsConnect:

OPHP also administers Healthy KidsConnect; a private insurance option for children in families above 200 % up to and including 300% FPL, who do not have access to employer-sponsored insurance or choose not to enroll in it. Healthy KidsConnect provides direct subsidies to children on a sliding scale based on family income. Children in families with incomes above 200 percent FPL are not eligible for CHIP OHP Plus.

- **Families with incomes above 200 up to and including 250 percent of FPL will pay a maximum of 10% of the child's monthly premium; and**
- **Families with incomes above 250 up to and including 300 percent of the FPL will pay a maximum of 15% of the child's monthly premium.**
- **Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.**

Private insurance carriers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP OHP Plus benefit package. Carriers are licensed and regulated by the Oregon Insurance Division. They must adhere to rules and regulations specific to commercial insurers. The managed care plans that contract with the State to offer this coverage provide a private sector insurance product with potential variations in the scope of coverage that meet the State's comparability requirements, but are unique to the carrier in terms of their particular coverage and how they manage their benefits (e.g. use of prior authorization or other service limits). Enrollees of HKC will have a choice of Health plans. There is 1 insurer that is offered statewide, as well as 4 regional insurers that will be offered in various regions of the state.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care

consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Oregon Administrative rules for quality assurance and quality improvement review process require DMAP contracted prepaid health plans to have an internal utilization review infrastructure and to specifically monitor utilization of preventive care, the operation and outcome of referral procedures, and persistent or significant DMAP member complaints. DMAP staff annually reviews health plan compliance with utilization and quality assurance requirements to ensure appropriate utilization of health care services. The quality improvement process ensures services provided are appropriate and medically necessary, and approved by the state. The following are examples of administrative mechanisms required of the managed care plans in the Oregon Health Plan Medicaid Demonstration Project, which are also required under CHIP to ensure CHIP children receive appropriate and medically necessary health care.

- **Plans must provide 24-hour-a-day, 7 day-a-week appropriate urgent, emergent, and triage services. Plans are required to have written policies and procedures that they communicate to providers, and plans are required to review their policies and procedures annually.**
- **Plans must ensure and monitor the availability of an after-hours call-in system to triage urgent and emergent call from clients.**
- **Plans must assure access to services according to the following time standards:**
  - **Immediately for emergency medical services. Within 24 hours for emergency dental, mental health, or chemical dependency services.**
  - **Within 48 hours for urgent medical, mental health, or chemical dependency services. Within one to two weeks for urgent dental services.**
  - **Within four weeks, or within the community standard, for well care for preventive or non emergent medical services.**
  - **Within two weeks of patient request for intake assessment for mental health or chemical dependency services.**
  - **Within twelve weeks, or the community standard, for dental services.**

For CHIP services provided on a FFS basis, all utilization review requirements of Title XIX and the 1115 Demonstration apply. The Quality Improvement Organization (QIO) contractor reviews inpatient hospital services. DMAP requires prior authorization for certain services

according to OHP Medicaid FFS protocols and claims are subject to SURS post-payment review.

The OPHP private market carrier contract will require that the carriers have quality assurance rules and a quality improvement review process in place to ensure that the services provided are appropriate and medically necessary. It will include an internal utilization review infrastructure that monitors utilization of preventive care, the operation and outcome of referral procedures, and persistent or significant Healthy KidsConnect enrollee/guardian complaints.

Carriers require prior authorization for certain services according to the guidelines developed in accordance with its Care Management Department's requirements.

Healthy KidsConnect quality assurance staff annually review health plan compliance against utilization and quality assurance requirements to ensure appropriate structures are in place to monitor utilization of health care services.

Section 4. Eligibility Standards and Methodology. *(Section 2102(b))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ Geographic area served by the Plan:
The entire state of Oregon, except Unborn coverage is restricted to Benton, Clackamas, Deschutes, Hood River, Jackson, Lane, Lincoln and Multnomah Counties (Lincoln County expanded October 1, 2009 through December 31, 2009)

Deleted: to

4.1.2. ☒ Age:
Birth to age 19, except for Unborn coverage restricted to Benton, Clackamas, Deschutes, Hood River, Jackson, Lane, Lincoln and Multnomah Counties) which is from conception to birth. (Lincoln County expanded October 1, 2009 through December 31, 2009)

4.1.3. ☒ Income:
CHIP OHP Plus direct coverage:
Birth to six, family income of 133% FPL up to and including 200% FPL, ages 6 to 19, family income 100% up to and including 200% of FPL. Except for redeterminations, we use income in the month of application for the countable income test. For redeterminations, we use the month the Department initiates the redetermination or the last month of current program eligibility. We use gross income, unless they are self employed. When they are self-employed we use adjusted income (allowing for deductions for business costs, or a 50% exclusion). If not eligible using the initial month of determination, we use the same application and reevaluate countable income using income in any calendar month in the 45 days after the date of application. For purposes of income determination the definition of a child's family will be the same as the state's OHP Title XIX family composition definition, whichever applies. When we evaluate the client for eligibility under CHIP or Medicaid we begin by looking at TANF related medical, All wages paid by the Census Bureau for

Deleted: The average of two months gross income is evaluated first.

Deleted: , using an average income from the budget month and the prior month. If still not eligible, then we look at budget month income only.

temporary employment related to Census activities and payments made for cash medical support are disregarded.

Unborn coverage:
0% to 185% of the FPL (and not eligible for Medicaid).

FHIAP ESI coverage:
Children birth to age 19 with Income zero up to and including 200% of FPL who meet the Title XXI definition of a targeted low-income child and who choose ESI and enrolled in FHIAP. Children who opt for FHIAP are not subject to title XXI benefit and cost sharing rules, and receive waiver authority for this under the Section 1115 demonstration.

FHIAP Individual health insurance:
Children birth to age 19 in families with income zero up to and including 200% FPL who meet the Title XXI definition of a targeted low-income child and who do not have employer-sponsored insurance available. Children who opt for FHIAP are not subject to title XXI benefit and cost sharing rules, and receive waiver authority for this under the Section 1115 demonstration.

Healthy Kids ESI Coverage:
Children birth to age 19 with family income from zero up to and including 200% of FPL who meet the Title XXI definition of a targeted low-income child and who apply for coverage through DHS and choose employer-sponsored insurance. Also Children birth to age 19 with family income above 200% up to and including 300% of FPL who meet the Title XXI definition of a targeted low-income child and choose employer-sponsored insurance instead of Healthy KidConnect plan. Children who opt for Healthy Kids are not subject to title XXI benefit and cost sharing rules, and receive waiver authority for this under the Section 1115 demonstration.

Healthy KidsConnect Private insurance option:
Birth to age 19 with family income above 200% up to and including 300% of FPL who meet the Title XXI definition of a targeted low-income child and who don't have ESI available or have it but choose not to accept it and enroll for coverage under the private insurance option. Coverage for Healthy KidsConnect is provided under the CHIP state plan and families have choice of ESI or HKC option.

4.1.4. ☒ Resources (including any standards relating to spend downs and disposition of resources):
No asset limit.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):
Oregon requires a Social Security Number (SSN) for CHIP unless the applicant is a member of religious sect or division of a religious sect that has continuously existed since December 31, 1950 and adheres to its tenets that prohibit applying for or using an SSN.

4.1.6. ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility): **N/A**

4.1.7. ☒ Access to or coverage under other health coverage:
The CHIP child must not have been covered by any private major medical health insurance in the past two months before application. The two months of uninsurance are the two months preceding the eligibility determination. This is done at every eligibility review for CHIP, regardless if a new applicant for CHIP, or not. The two-month waiting period is waived if any of the following are true: the person has a condition that without treatment would be life-threatening or cause permanent loss of function or disability; the person's private health insurance premium was reimbursed under the policy for reimbursement of cost-effective Employer Sponsored Health Insurance; the person's Insurance premium was subsidized by FHIAP; or the person met the two month uninsurance period while on the FHIAP reservation list even if they have since obtained coverage; a member of the filing group was a victim of domestic violence; or the person lost coverage due to the loss of employment of a parent(e.g.reduction in hours, employer stops providing coverage, etc). Examples of life-threatening or disabling conditions are cancer, asthma, diabetes. Oregon monitors substitution under the Community Human Service's Quality Control and Quality Assurance process to analyze the extent to which an applicant drops other health plan coverage. Records are reviewed to ensure that the two-month period of ineligibility policy is applied appropriately. Action is taken as needed. Trends are

monitored to ensure that the policy is consistently applied throughout the programs.

4.1.8. ☒ Duration of eligibility:

Eligibility is for 12 continuous months, unless one of the following events occurs before the annual renewal: 1) moves out of state; 2) obtains other health insurance; 3) a child turns age 19; 4) the family requests cancellation; 5) the family applies for Medicaid and the child is determined eligible for Medicaid or 6) if the child is enrolled in a HKC plan and does not pay the premium. Families with HKC children will have a minimum 30 days to pay their portion of the premium before being disenrolled. People in HKC are billed by OPHP each month for their portion of the premium. OPHP combines the member's portion with the subsidy and pays the insurance carrier. Individuals who fail to pay their premium will be disenrolled. Members are billed approximately 45 days in advance of the date premiums are due to the carrier. Members are provided a premium grace period of at least 30 days from the billing date. Reminder notices are mailed mid-way through this grace period. Subsidy cancellation notices outlining the program's intent to terminate, are mailed at the end of the grace period. Terminated individuals can be reinstated on a one time exception basis. Once terminated for non payment of premium members are able to re-enroll in the program. In order to do so, however, they must serve a new two-month period of uninsurance Eligibility is redeterminded every twelve months for State Plan children (at or below 200% FPL). No limit to duration of eligibility if all conditions are met. The Unborn population is eligible for CHIP benefits while in utero and redetermined at birth. Coverage for this population is restricted to counties referenced in 4.1.1.

4.1.9. ☒ Other standards (identify and describe):

Although eligibility is retroactive to date of CHIP application, the client is not eligible if the application does not include selection of a prepaid health plan in mandatory managed care areas for OHP Plus coverage. This is the same as the current rule applied to OHP Medicaid non-categorical members.

The twelve-month eligibility period for Healthy KidsConnect members begins on the date of application approval. Plan enrollment will be no earlier than the first of the month following eligibility approval. Enrollment in HKC plans is the first of the month following application approval, if application approval occurs on or before the 25th of the approval month. If application

approval is the 26th or after in the approval month, enrollment will be the first of the next month.

Express Lane Eligibility agencies include The Department of Human Services, Supplemental Nutritional Assistance Program (SNAP) and the Department of Education, selected districts, through the National School Lunch Program (NSLP).
The Department will use SNAP income findings and apply this income to the child who is applying for medical. The state will use SNAP findings on verification of SSN and state residency. The state will then verify citizenship.

The State Department of Education prepares the application form that all schools use for NSLP Each school district will then send DHS a list of children that are found eligible for free and reduced lunch whose parents did not 'opt-out' and who indicated the child does not have any kind of health coverage". DHS will then send "Express Lane" applications for health coverage to the identified families, requesting additional information. The additional information requested of families includes the names, genders, social security numbers, dates of birth, citizenship status, tribal information, availability of other insurance, disabilities, absent parent information, and managed care information for everyone applying. Applications that are returned will be processed to determine eligibility using regular methodologies including verification of citizenship. The Department will use the NSLP findings for income and household composition for initial eligibility determinations for children. The NSLP will send the Department households' income and household group size. The Department will send the households shortened applications, and when the applications are returned, the NSLP findings of income and eligibility group size will be used to determine eligibility for children.

The Express Lane option will be applied to initial determinations only.

4.1.10 ☒ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:

(1) "Qualified aliens" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;
(3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:
(a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
(b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;
(c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;
(d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and
(e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and
(4) Individuals in non-immigrant classifications under the INA who are permitted to remain the U.S. for an indefinite period, including the following who are specified in section 101(a)(15) of the INA:

- **Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;**
- **Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;**
- **Religious workers under section 101(a)(15)(R);**
- **Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(U) of the INA;**
- **Battered aliens; and**
- **Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.**

☒ **The State elects the CHIPRA section 214 option for**

children up to age 19.

☐ **The State elects the CHIPRA section 214 option for pregnant women through the 60 day postpartum period.**

4.1.10.1 ☒ **The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.**

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Oregon uses one application for CHIP and Medicaid. This application is obtained by calling the toll free application hotline number that provides application assistance and sends applications to people requesting applications. Applications may also be obtained and submitted on line via the internet, through outreach locations at FQHCs, Tribal health clinics, DSH hospitals, Healthy Start, local health departments and Certified Application Assistance Organizations, Outreach Grant Organizations and DHS branch. Potential clients that submit an application over the Internet must affirm that the information supplied is true under penalty of perjury. Applicants are informed of the Medicaid and CHIP program in the application packet. The applicant sends the application to the OHP Central Processing Center. Eligibility workers first screen the application to determine if the child is eligible for OHP Medicaid, using the initial gross income test standard and applicable resource standards. If the child is over income for OHP Medicaid, the application is then screened for CHIP eligibility. The same eligibility workers conduct this eligibility determination process, thus coordinating and streamlining the procedures. Once eligibility has been established, the applicant is notified of eligibility and they receive a new member packet. The eligibility period for all children, Medicaid and CHIP is 12 months.

To facilitate continuous health care coverage for eligible children, the OHP application processing center sends a notice and a new simplified redetermination form to enrollees notifying them that their coverage is scheduled to end soon. Enrollees receive a reapplication packet and two additional notices before coverage is terminated. However, the recipient does not need to complete a new application; they can contact their worker or local branch and establish a request for medical assistance. Once they have initiated a new date of request, an eligibility worker must review the recipient's eligibility and request verification necessary for the new eligibility determination.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state. **Oregon's OHP Plus CHIP program and Healthy KidsConnect does not currently have an enrollment cap. The children opting for the FHIAP 'premium assistance' program may have enrollment limited if enrollment numbers exceed**

FHIAPs biennial budget. Enrollment would be allowed to reduce by attrition methods or close to new applicants.
Children in families with income from zero up to and including 200 percent of the FPL currently on the FHIAP Reservation List:
The State will perform targeted outreach to families on the existing reservation list to ensure they are aware that children also have the option to receive direct state plan coverage at any time under Medicaid or CHIP. Families with children will be sent information about direct coverage through Healthy Kids, along with a Healthy Kids application, and a letter encouraging families to apply for immediate coverage rather than wait on FHIAP's reservation list. Families must either complete the application or actively decline direct coverage. All children that choose FHIAP at the point of application and choose to go on the reservation list will also receive information on direct coverage options and be informed that they can move from the FHIAP reservation list or decline CHIP or Medicaid coverage, but still be given the opportunity to choose to move to direct state plan coverage at any time.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))
Oregon uses one application for CHIP and Medicaid. This application is obtained by calling the toll free application hotline number that provides application assistance and sends applications to people requesting applications. Applications may also be obtained and submitted on line via the Internet, through outreach locations at FQHC, Tribal health clinics, DSH hospitals, Healthy Start, local health departments and Certified Application Assistance Organizations, Outreach Grant Organizations and DHS branch offices. Potential clients that submit an application over the internet must affirm that the information supplied is true under penalty or perjury. Applicants are informed of the Medicaid and CHIP program in the application packet. The applicant sends the application to the OHP Central Processing Center. Eligibility workers first screen the application to determine if the child is eligible for OHP Medicaid, using the initial gross income test standard and applicable resource standards. If the child is over

income for OHP Medicaid, the application is then screened for CHIP eligibility. The same eligibility workers conduct this eligibility determination process, thus coordinating and streamlining the procedures. Once eligibility has been established, the applicant is notified and receives a new member packet. The eligibility period for Medicaid and CHIP is 12 months

The OHP Central Processing Center conducts standardized audits on an ongoing basis to review eligibility determination to ensure that children who are Medicaid eligible, or have access to a state employee health plan, or have private coverage are not enrolled in CHIP.

To facilitate continuous health care coverage for eligible children, the OHP application processing center sends a notice and a new simplified redetermination form to enrollees notifying them that their coverage is scheduled to end soon. Enrollees receive a total of three notices before coverage is terminated. However, the recipient does not need to complete a new application; they can contact their worker or local branch and establish a request for medical assistance. Once they have initiated a new date of request, an eligibility worker must review the recipient's eligibility and request verification necessary for the new eligibility determination.

In addition, children enrolled in the CHIP program are instructed to notify the program in the event they become pregnant (0-185% of FPL), in which case they will be moved to the Title XIX Poverty Level Medical Program for pregnant women until their eligibility in that category expires. Most children born to women in the Medicaid PLM program are eligible for Medicaid for one year. Before that year is up, we send notification they may be eligible for CHIP when that year is up. The Children who are eligible for CHIP because their household income is between 185-300 % of FPL and who are or become pregnant will remain in CHIP. Babies born to these CHIP children will have assumed eligible newborn status in CHIP for their first year of life. Children above 200% up to and including 300% born into subsidy families do not have assumed eligible newborn status. However, when adding the baby, the worker determines if there would be a decrease in the family's subsidy level, we add the baby for the balance of the existing 12-month eligibility period at the existing subsidy level (i.e., we would

not apply the decrease in benefits at that time). At the end of the 12-month period, we would redetermine eligibility, update the income information (which could affect the subsidy level) and establish a new 12-month eligibility period for everyone in the family.

Screen and enroll requirement under Express Lane Eligibility:
☐ **The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe this process.**

☒ **The State is establishing a screening threshold set as 30 percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child. The thresholds for all children based on 163% FPL.**

☐ **The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.**

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))
See 4.4.1 above.

4.4.3. The State is taking steps to assist in the enrollment in CHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))
Oregon uses one application for CHIP and Medicaid. This application is obtained by calling the toll free application hotline number that provides application assistance and sends applications to people requesting applications. Applications may also be obtained and submitted on line via the Internet, through outreach locations at FQHCs, Tribal health clinics, DSH hospitals, Healthy Start, local health departments and Certified Application Assistance Organizations, Outreach Grant Organizations and DHS branch offices. Potential clients that submit an application over the internet must affirm that the information supplied is true under penalty or perjury Applicants are informed of the Medicaid and

CHIP program in the application packet. The applicant sends the application to the OHP Central Processing Center. Eligibility workers first screen the application to determine if the child is eligible for OHP Medicaid, using the initial gross income test standard and applicable resource standards. If the child is over income for OHP Medicaid, the application is then screened for CHIP eligibility. The same eligibility workers conduct this eligibility determination process, thus coordinating and streamlining the procedures. Once eligibility has been established, the applicant is notified and receives a new member packet. The eligibility period for Medicaid and CHIP is 12 months.

In an effort to maximize enrollment of CHIP children the Application Assistance Program (AAP). Certified Application Assistance Organizations (CAAO) will provide application assistance to potential CHIP eligibles. An organization is certified as a CAAO if they are doing business in the state of Oregon and registered with the Secretary of State. Upon completion of an application with DHS and signing an agreement to use trained application assisters and conduct criminal background checks on application assisters the entity is certified as a CAAO. Oregon will not limit the number of organizations that are certified as a CAAO. Organizations, existing or new may not participate in both the AAP and Outreach and Enrollment grant programs. Organizations that provide medical services are not eligible to be CAAO certified, these include clinics, hospitals, FQHCs, MCO or Public health departments. These non certified CAAO organizations are currently in a program which allows them to use a "date stamp" in order to establish a date of request for client's presenting themselves for medical care. We do not provide compensation to these providers.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

DHS has specific measures to prevent the clients from substituting CHIP

coverage for group health coverage. The first measure is that persons covered by private health insurance are not eligible for benefits under CHIP. Another measure to prevent substitution is that children are ineligible if they have been covered by a group health plan two months immediately preceding the application for CHIP. There are exceptions to the two-month rule, such as when the child has a life threatening or disabling conditions.

DHS also requires that insurance information on the persons seeking medical assistance coverage be provided on the application for CHIP as a measure to avoid substitution for group health coverage. DHS enrollees' TPR information is maintained in the MMIS system. In addition to self reported insurance information, the OHP Central Processing Center receives TPR insurance information from providers which is verified by Central Processing staff. Eligibility staff also reviews pay stub information that may also indicate whether dependent health insurance is being deducted from the employee paycheck. The State monitors substitution under its Quality Control and Quality Assurance process to analyze the extent to which an applicant drops other health plan coverage. Records are reviewed to ensure that the two-month period of ineligibility is applied appropriately. Action is taken as needed. Trends are monitored to ensure that the policy is consistently applied throughout the program.

Targeted, low-income children of employees of the State of Oregon, who are eligible for employer sponsored insurance benefits, are not eligible for CHIP coverage since the State provides coverage of dependents.

The OHP Central Processing Center conducts standardized audits on an ongoing basis to review eligibility determinations to ensure that children who are Medicaid eligible, or who have private coverage are not enrolled in CHIP. The Quality Assurance Unit at OHP Central Processing conducts random audits on an ongoing basis of eligibility determinations to monitor the integrity of determinations. All eligibility elements are reviewed during this process, including assessment of the client's access to TPR and the substitution of coverage.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable. Same as listed under 4.4.4.1

4.4.4.3. ☒ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify

specific strategies in place to prevent substitution. Same as listed under 4.4.4.1

4.4.4.4. ☒ If the state provides coverage under a premium assistance program, describe:

The FHIAP program is described throughout this state plan. Only the aspects which are different from direct coverage children are referenced. The employer contributions and benefits are outlined in the Medicaid Section 1115 demonstration project.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))
Targeted low-income children who are American Indian or Alaska Native are subject to the same eligibility determination protocol as other targeted low-income children. Due to the unique characteristics of this population, DMAP works with representatives of the tribes in the state through the American Indian/Alaska Native Forum and the N.W. Portland Area Indian Health Board (PAIHB) to develop outreach protocols that specifically target low income children in the state who are American Indians or Alaska Natives. Representatives of the Department of Human Services meet quarterly with representatives of the nine federally recognized tribes in the state, the PAIHB and the Portland Indian Health Service. CHIP has been and continues to be a recurring agenda item at these meetings. CHIP policy will mirror OHP Medicaid policy for children in the state who are American Indians or Alaska Natives. Children of recognized Indian heritage will not be required to enroll in managed care and may receive services on a FFS basis, if they choose. Options for tribal participation in CHIP are open. There is a possibility of future Title XXI State Plan amendments if the tribes decide they want to do something different for their children.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

Outreach for CHIP will be incorporated into existing OHP Medicaid outreach activities, including:

- **VISTA Health Links;**
- **DSHs Hospitals, FQHCs and tribal health clinics local health departments.**
- **Hospital hold;**
- **SAFENET;**
- **Outreach through Healthy Start.**

These programs are described in more detail in Section 2.2.1
Application Assistance:

An additional program starting in October 2009 to maximize enrollment of children is the Application Assistance Program (AAP). Certified Application Assistance Organizations (CAAO) will provide application assistance to potential CHIP eligibes. In order to become a CAAO an organization must be registered with the Secretary of State and be free from a conflict of interest. The CAAO must complete an application with DHS and sign an agreement to use trained application assisters and conduct criminal background checks on application assisters the entity is certified as a CAAO. Oregon will not limit the number of organizations that are certified as a CAAO. Organizations, existing or new may not participate in both the AAP and Outreach and Enrollment grant programs. The types of organizations that can be CAAO are health advocacy groups, Boys and Girls Clubs, Faith based groups and insurance agents. Application Assistance Program contracts will be renewed within state contract schedules. There will be no competitive bid process as the program is available to any organizations that qualify to participate.

Organizations that provide medical services are not eligible to be CAAO certified, these include clinics, hospitals, FQHCs, MCO, schools, individuals, Public health departments or anyone that may have a conflict of interest. These non-certified CAAO organizations are currently in a program which allows them to use a "date stamp" in order to establish a date of request for client's presenting themselves for medical care. We do not provide compensation to these providers.

The Application Assistance Program is used for both CHIP and Medicaid enrollees. Only after an application is processed and the client is enrolled in OHP will DHS pay $50 to the CAAO. The method developed to account for this payment is that each CAAOs will have a date stamp that will include their own unique code. They will stamp each application or type it on for applications submitted electronically. Once the application is received at the OHP processing center that code will be entered into their case file along with the other client date. Our system has the ability to report the status (Approved, denied or pended) of applications by CAAO. We will run a monthly report and pay the organization for each application approved during the past month.

The amount per application was determined by information provided by other states using this method and approved by DHS executive staff and the Governors Health Policy Advisor. The role of a CAAO is to assist families in applying for Healthy Kids. They are expected to find uninsured kids, educate them on the Oregon Health Plan, assist the family in completing an application, assist the family in obtaining necessary documents and ensure the application is submitted. CAAO staff will also assist the family on any necessary follow up, if needed.

Outreach and Enrollment Grants:
The Targeted Outreach and Enrollment Grant Program is designed to provide culturally-specific and targeted outreach and direct application assistance to aid families in racial, ethnic and language minority communities, living in geographic isolation or with additional access barriers to enroll their children into the Healthy Kids program. The Outreach and Enrollment Grantee will target geographic areas with high rates of eligible but unenrolled children, including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness. Grant funds are intended for staff time, local travel, and other expenses necessary to reach and provide assistance to targeted families with children. DHS will provide technical assistance and training, publications and other promotional materials

The targeted Outreach and Enrollment Grant program will provide funding opportunities to community organizations that apply and are selected for an award. The funds must be used for activities that will lead to enrollment of children into the Oregon Health Plan for both Medicaid and CHIP. Activities funded may include, but are not limited to, community education, application assistance, and participation in community events. Outreach grants will be awarded to community organizations specifically targeting enrollment of children in racial, ethnic and language minority communities; living in geographic isolation; and/or with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental

disabilities or chemical dependency; and those experiencing homelessness.

The criteria used to award an outreach and enrollment grant are:

(1) Ability to Target geographic areas with high rates of eligible but unenrolled children, including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness;

(2) Demonstrate that they have access to, and credibility with, target populations; and

(3) Demonstrate that they have the ability to address barriers to enrollment, such as a lack of awareness, stigma concerns and punitive fears or cultural barriers.

(4) Are not currently a CAAO participating in the AAP.

Outreach and Enrollment Grants will begin effective upon CMS approval on or after October 1, 2009. The grant will be for the balance of state fiscal year 2010 and renewable for a second year, based on performance. Grants will range from $20,000 to $80,000 a year. We anticipate awarding approximately 20 to 40 grants in the first biennium. Each grantee will have enrollment targets that they have proposed in their application and will have been approved by Office of Healthy Kids. Grantees will be required to provide monthly reports on their progress. Fund disbursement will be contingent upon demonstrating progress toward their goals. The Office of Healthy Kids will be fully staffed with at least one FTE monitoring their progress and providing technical assistance.

Outreach and Enrollment Grant agreement statement of work includes, but is not limited to:

Identifying its target population(s);

- **Distributing DHS-approved promotional, educational and marketing materials to its targeted population**
- **Completing application assistance training, provided by DHS;**
- **Participating in meetings and conferences as requested by DHS;**
- **Assisting its targeted population in completing the enrollment process into the Healthy Kids program, in accordance with the application assistance training;**
- **Collaborating with local community organizations and establishing information-sharing processes as needed.**
- **Submitting its progress to DHS on monthly and annual basis according to reporting requirements specified by DHS, including the number of families contacted and the number of children enrolled successfully;**

- **Conducting outreach that is results driven and connected to actual enrollment and retention of children; and**
- **Developing strategies to overcome barriers that families in the target population may have, and establishing relationships of trust to effectively support enrollment;**

Express Lane Eligibility:
The DHS utilizes SNAP and NSLP as indicated in section 1.4 in order to provide a simplified eligibility determination process and expedited enrollment of eligible children in Medicaid and CHIP. For initial determinations the Department will utilize income findings from these designated agencies to automatically enroll children in Healthy Kids if they meet the other eligibility criteria. Families will be contacted by phone and children will be enrolled if their parents give verbal or written approval.

The Department has ongoing outreach activities as indicated above, to increase enrollment for the health kids programs and have worked with the Department of Education and statewide education organizations to facilitate the express lane eligibility through the NSLP. Agency staff has been trained and will have access to ongoing training.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☒ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project **Program rules are available at http://www.dhs.state.or.us/policy/healthplan/guides/main.html**

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☒ Other (Describe) **Healthy KidsConnect: This is a private insurance option available to children under the CHIP state plan. Sliding scale subsidies are available to children who enroll in State-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans are comparable, but not identical to OHP Plus benefit package.**

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**
As long as the Section 1115 waiver authority is effective, children who opt to take up premium assistance are not subject to title XXI benefit rules. Healthy KidsConnect participants receive benefits that are comparable, but not identical to OHP Plus benefits and are delivered through the private insurance marketplace. The insurer's contract identifies services not covered as benefit limitations and exclusions rather than by use of the prioritized List, which defines the CHIP OHP Plus benefit package. Both CHIP OHP Plus and HKC contain the benefit elements listed below.

***Applicable for Unborn population only- When any grouping below is**

provided only if medically necessary and/or limited to emergency for the Unborn population it is identified with *L/MN.
Services for the Unborn population are the same benefits, regardless of county, (subject to section 4.1.8) as identified in items 6.2.1 through 6.2.28.

Section	Benefit description	Eligibility Groups covered by the state plan	Conception to birth
6.2.1.	Inpatient services **(Section 2110(a)(1))**	☒	☒
6.2.2.	Outpatient services **(Section 2110(a)(2))**	☒	☒
6.2.3.	Physician services **(Section 2110(a)(3))**	☒	☒
6.2.4.	Surgical services **(Section 2110(a)(4))**	☒	☒ *L/MN
6.2.5.	Clinic services (including health center services) and other Ambulatory health care services. **(Section 2110(a)(5))**	☒	☒
6.2.6.	Prescription drugs **(Section 2110(a)(6))**	☒	☒
6.2.7.	Over-the-counter medications **(Section 2110(a)(7))**	☒	☒
6.2.8.	Laboratory and radiological services **(Section 2110(a)(8))**	☒	☒
6.2.9.	Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**	☒	☒
6.2.10.	Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**	☒	☒
6.2.11.	Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**	☒	☒
6.2.12.	Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**	☒	☒ *L/MN
6.2.13.	Disposable medical supplies **(Section 2110(a)(13))**	☒	☒ *L/MN
6.2.14 .	Home and community-based health care services (See instructions) **(Section 2110(a)(14))**	☒	☐
6.2.15.	Nursing care services (See instructions) **(Section 2110(a)(15))**	☒	☒
6.2.16.	Abortion only if necessary to save the life of the	☒	☐

mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**
**** state only -funded abortion services are available to CHIP OHP Plus and HKC**

6.2.17. Dental services **(Section 2110(a)(17))**	☒	☒*L/MN
6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**	☒	☒*L/MN
6.2.19. Outpatient substance abuse treatment services **(Section 2110(a)(19))**	☒	☒*L/MN
6.2.20. Case management services **(Section 2110(a)(20))**	☒	☒
6.2.21. Care coordination services **(Section 2110(a)(21))**	☐	☐
6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**	☒	☒*L/MN
6.2.23. Hospice care **(Section 2110(a)(23))**	☒	☐
6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**	☒	☒*L/MN
6.2.25. Premiums for private health care insurance coverage **(Section 2110(a)(25))(HKC and ESI)**	☒	☐
6.2.26. Medical transportation **(Section 2110(a)(26))**	☒	☒*L/MN
6.2.27.Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))(except those enrolled in HKC)**	☒	☐
6.2.28.Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**	☒	☐

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-

income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

For CHIP OHP Plus, DMAP contracted prepaid managed care plans results of consumer satisfaction surveys, EQRO and site review identify areas that need system improvements in quality of or access to care. DMAP measures well-baby care/child/adolescent care and childhood immunizations through the use of HEDIS performance measures. The results of these measures are reported by FCHP, as well as fee-for-service. In addition, access to primary care provider and measures of early childhood cavities prevention efforts are measured.
Health KidsConnect private option plans are licensed and regulated by the Department of Consumer and Business Services (DCBS), Oregon's insurance division. The regulations for Health insurers require the carriers to report annually to DCBS on grievance and appeals, utilization review policies, quality assessments activities and health promotion and disease prevention activities, including a summary of screening and prevention health care activities covered by the insurer, as well as the scope of the insurers network and to the accessibility of services. Health insurers measure well-baby care/child/adolescent care and childhood immunizations through the use of HEDIS performance measures.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☒ Information strategies
7.1.4. ☒ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

CHIP OHP Plus: CHIP services will be provided through Oregon's existing OHP Medicaid Demonstration delivery system. The managed

care plans are contracted directly with DMAP (described in Section 3.1).Since 1994, health plans that contract with the state to provide Title XIX services have been required to adhere to established quality assurance methods and protocols. As the state of the art of managed care quality assurance has changed and become more sophisticated, so have Oregon's requirements for plan participation. Activities of the OHP Medicaid Demonstration quality improvement program extend to CHIP OHP Plus coverage. This assures CHIP OHP Plus members will receive the same quality of care and access to care currently provided to OHP Medicaid members. Specific studies of the quality of care and access to care of CHIP OHP Plus members are conducted within the context of ongoing DMAP quality improvement and evaluation efforts. As described in DMAPs Oregon Health Plan Administrative Rules and the General Rules, Prepaid Health Plans (PHPs) that contract with DMAP must meet specific mandatory obligations designed to assure quality, medically appropriate care for all OHP enrollees. The data specifications and reporting requirements outlined in the Rules are consistent with CMS's quality initiatives for Medicaid managed care. All services provided to children enrolled in Oregon's CHIP OHP Plus program will meet the same standards of quality assurance and medically appropriate care as currently provided by OHP Medicaid. With respect to health care delivery systems, DMAP has many contractual requirements for plan participation. PHPs must meet various quality assurance reporting requirements, including the following:

Reporting Area Quality Assurance Requirement

Plan Infrastructure and Management
Solvency plan and financial reporting

- **Medical and dental record keeping system**
- **Utilization control requirements and review procedures**
- **Credentialing and recredentialing procedures**
- **Information materials for the orientation of new members and the continuing education of existing members**
- **Provider compensation and turnover rates**

Access/Availability Utilization of Medically Appropriate Covered Services, including:

- **Inpatient/Outpatient care;**
- **Maternity and newborn care;**
- **Ambulatory care;**
- **Preventive care; and**

- **Emergency services**
- **Sufficient quantity of providers to ensure adequate capacity**
- **24-hour-a-day, 7-day-a-week emergency and urgent care services**
- **Language and transportation services**
- **Medical Case Management services**
- **ADA compliant physical access to facilities and providers**
- **Community Standards governing scheduling, rescheduling and waiting time for scheduled appointments**
- **Client Referral system**

Reporting Area Quality Assurance Requirement
Quality of Care

- **Documented policies and procedures for member care**
- **External review of policies and procedures relating to member care and medical record review for quality of care**
- **Internal Quality Assurance and Quality Improvement programs based on written policies, standards and procedures**
- **Quality assurance committee structure and membership guidelines**

Member Rights

- **Due process rights; including a formal complaints and hearings process**
- **Rights to informed consent**
- **Rights to treatment with dignity and respect**
- **Other processes establishing and maintaining rights to adequate medical care**

Clinical Measures and Utilization
The Health Plan Employers Data Information Set (HEDIS) and statewide goals described in Oregon Shines II, the state's 20-year strategic plan, serves as the basis on which CHIP OHP Plus health care is assessed for quality and appropriateness of care. DMAP collects the following health measures specific to the population of OHP clients under 19 years of age:

- **Access to Primary Care Provider**
- **Childhood Immunizations**
- **Well-Baby, Child and Adolescent Visits**
- **Annual dental visit**

Over 85 percent of CHIP OHP Plus children are enrolled in managed care. DMAP evaluates and monitors the measures listed above for each

health plan. These measures are used as part of our periodic on-site reviews of each health plan to promote access to necessary services. DMAP does not currently sanction plans for not meeting minimum performance levels for these measures. However, DMAP has both a Quality Improvement Coordinator and a Prepaid Health Plan coordinator assigned to each plan to monitor access to services and performance on these critical indicators. If problems are encountered, these staff members work with the health plans to establish and monitor corrective action plans in order to achieve acceptable performance.

Contracted health plans are required to have written policies and procedures and monitoring systems that provide for emergency and urgent services for all DMAP Members on a 24-hour, 7-day-a-week basis.

Contracted health plans are required to have written policies, procedures and monitoring systems that ensure the provision of Case Management Services for all OHP clients, to coordinate and manage services, and to ensure that referrals made are noted in the patient's clinical record. Plans are required to develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable Alternative Care Settings, for all services covered by agreements with DHS. Health plans must ensure that access to and quality of care provided in all referral settings is monitored.

Other Efforts to Improve Quality of and Access to OHP Services:

Quality
DMAP coordinates the activities of the Department of Human Services' Oregon Health Plan Quality Improvement Committee (OHPQIC). The OHPQIC is responsible for advising and guiding the quality improvement efforts of all administrative components of the OHP and will serve a similar role in assessing the CHIP OHP Plus. The overall mechanism for quality improvement, administered by DMAP requires PHPs to have an active Quality Improvement Process (QIP) in place and integrated with other management functions. QIP performance is evaluated annually and involves review against standards in the following areas:

- **Member Care is measured against current, relevant, criteria for care.**
- **Medical and Dental Records are reviewed for structure and completeness.**
- **Quality Improvement Program Policies and Standards are reviewed and refined to meet changing conditions and needs.**
- **Comorbidities and Special Needs are reviewed before denial of a**

service and review of notices of denials.

- **Member Access to Service and Utilization of Service is evaluated by site examination of PHP policies and practices and encounter data claim validation.**
- **Member Educational Plans and Provider Information are evaluated by site examination of PHP policies, practices and materials.**
- **Preventive care, adequacy of medical or dental record keeping;**
- **Operation and outcome of referral procedures;**
- **Medication reviews;**
- **Appointment systems;**
- **After-hours call-in system;**
- **Emergency services;**
- **Denials of service;**
- **PHP-initiated disenrollments;**
- **The access plan and out-of-plan access;**
- **Encounter data management**; and
- **Timeliness and appropriateness of referrals.**
- **DMAP also reviews for compliance with its Administrative Rules which set standards for access, provider credentialling and other structural measures of quality.**

Oregon's PHPs have adopted selected elements of NCQA standards as the basis for their quality improvement programs, credentialing systems, record keeping, and utilization review. DMAP also contracts with an External Quality Review Organization (EQRO) for medical record review of a representative sample of OHP Medicaid clients to determine the quality of care they receive. Recent EQRO studies include prenatal care, diabetes management and depression.

Access and Member Satisfaction
DMAP conducts surveys of members to determine satisfaction with access to medical services in terms of distance and appointment availability. Americans with Disabilities Act (ADA) access is reviewed in the survey of adult populations and children's access to service with the children's form of the Consumer Assessment of Health Plans Study (CAHPS) survey. Oregon has established a biennial member satisfaction survey using the nationally standardized CAHPS instrument to assess members experiences of access, satisfaction, and system performance.

Quality Assurance and Utilization Review
Oregon has built on the successful design, implementation, and improvement of the OHP Quality Improvement Program for CHIP OHP

Plus. PHPs monitor the quality of care using a number of aspects of care, including outcomes of selected procedures. Each PHP is responsible for the maintenance of the organizational and methodological structures (such as Quality Improvement Committees and reviews of adverse events) necessary to ensure the quality and appropriateness of care.

Preventive Care
Oregon's emphasis on primary prevention is best demonstrated through the activities of Project: PREVENTION! a management and quality initiative developed by DMAP in the Spring of 1996 in partnership with the Public Health Division and the OHP managed care plans. The goal of Project: PREVENTION! is to assure the presence and effectiveness of preventive health care services for OHP clients. A task force identified and recommended appropriate preventive health practice measures for individual plans to target and accelerate. In addition, Project: PREVENTION! developed a joint-venture partnership with OHP plans, the Public Health Division, non-OHP plans and county health departments on one unified statewide measure, an electronic pediatric immunization registry, Immunization ALERT. Immunization ALERT is a comprehensive immunization registry designed to give providers access to current and complete childhood immunization records despite changes in family residence, health insurance and choice of health provider if the child remains in Oregon.

Project: PREVENTION! supports a statewide tobacco cessation effort that involves partnership with medical and dental managed care plans, the Public Health Division and the Tobacco Free Coalition of Oregon. Central to the tobacco cessation project is the collective identification, education, and treatment of tobacco users. Medical and dental providers developed programs to help prevent children and adults from starting to use tobacco and have increased their efforts to help them quit. Project: PREVENTION! also adopted HEDIS technical standards for use in the measurement of childhood and adolescent immunization status, diabetes and asthma.

In 2001 Project: PREVENTION! adopted Early Childhood Cavities Prevention as the focus for prevention efforts. These efforts are ongoing with the FCHPs and DCOs.

Healthy KidsConnect: Plans are licensed and regulated by the Department of Consumer and Business Services. The Insurance division's administrative rules contain many of the

Elements described above for DMAP's contracts with prepaid health plans. These include but are not limited to, benefit design, reporting quality assurance, enrollee rights, screening and prevention health care activities and the accessibility of services.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

CHIP OHP Plus: PHPs that contract with DMAP are required to follow established rules concerning access and availability of covered services outlined in the Oregon Health Plan Administrative Rules under rule OAR 410-141-0220: Oregon Health Plan Prepaid Health Plan Accessibility. Requirements of this rule include:

- **Written policies and procedures that establish standards for access, capacity, risk assessment, interpreter services, and ADA compliant accommodation to ensure access to health care services to all OHP members**
- **Geographic proximity of facilities and appointment wait times as determined by the prevailing Community Standard**
- **Sufficient provider panels and networks to ensure adequate service capacity to provide availability of, and timely access to, medically appropriate services**
- **Professional expertise among providers to treat or otherwise accommodate the full range of medical, dental or mental health conditions experienced by OHP members**
- **Monitoring systems to assure access to services according to time standards as indicated by the nature of the appointment including:**
- **Emergency care – Immediately for physical. Within 24 hours for dental, mental, or chemical dependency.**
- **Urgent care – Within 48 hours for physical, mental or chemical dependency, as indicated. Within one to two weeks for dental.**
- **Well Care, Routine, Preventive or Non-urgent – Within four weeks or the Community Standard for physical. Intake assessment for mental or chemical dependency within two weeks of patient request. Within twelve weeks for dental.**
- **Maintenance of 24-hour telephone coverage with a live operator (not a recording) guided by established standards pertaining to Primary Care Provider (PCP) call-back and back-up in the areas of:**
  - **Emergency, urgent, and routine issues**
  - **Internal Medicine, Family Practice, OB/Gyn, and Pediatrics**
  - **Interpretive services after office hours**

DMAP and the PHPs monitor all access issues from both the planning and implementation perspective. Regular reports, site inspections, internal and external audits, and consumer satisfaction surveys serve to validate the effectiveness and timeliness of access to covered medical services.

Healthy KidsConnect: Plans are licensed and regulated by the Department of Consumer and Business Services (DCBS), Oregon's Insurance division. The Insurance division's administrative rule contain many of the elements described for DMAPs contracts managed care plans above, such as benefit design, reporting quality assurance, enrollee rights, screening and prevention health care activities and the accessibility of services. Health insurers in Oregon are required to provide the enrollee with information relating to covered services, access, scheduling as well as how emergency medical conditions are covered and accessed including a statement of prudent layperson standards for emergency treatment.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

CHIP OHP Plus: PHPs are required to assure access to the services they provide including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to DMAP Members in terms of timeliness, amount, duration and scope as those services are to non-DMAP persons within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to DMAP and provide reasonable alternatives for Members to access care that must be approved by DMAP. PHPs have a monitoring system that demonstrates to DHS, as applicable, that the plan has surveyed and monitored for equal access of DMAP Members to referral providers pharmacy, hospital, vision and ancillary services.

Healthy KidsConnect: Plans are private insurers and regulated by the Oregon Insurance Division. The Insurance Division requires that commercial group health insurers submit their benefit plan designs and premium rates through an approval process. The HKC plans are considered Discretionary group plans and will be reviewed by the Insurance Division. This review by the Division helps assure that the Healthy KidsConnect benefit plans meets all Division requirements. The ultimate focus of the Insurance Division approval process is to protect

the consumer.

Benefit plans need not include an out-of-network benefit except for emergencies. The Healthy KidsConnect benefit plan excludes any out-of-network benefit except for emergencies or in cases for which the insurer provides a prior authorization. When out-of-network providers are authorized or emergent, the insurers will cover them as in network services.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

CHIP OHP Plus: DMAP requires PHPs to make a determination on authorization requests within two working days of receipt of an authorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in skilled nursing facility. Authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If an authorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72 hour supply if the medical need for the drug is immediate.

For all other pre-authorization requests, PHPs shall notify providers of an approval, a denial or a need for further information within 14 calendar working days of receipt of the request.

Healthy KidsConnect: private Plans are required by DCBS OAR to respond to requests for prior authorization of nonemergency services within two business days and must have qualified health care personnel available for same day telephone responses to inquiries concerning certification of continued length of stay. Emergency services do not require prior authorization.

Section 8. Cost Sharing and Payment *(Section 2103(e))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☒ YES, **Cost sharing applies to Healthy KidsConnect, FHIAP and Healthy Kids ESI.**
As long as the Section 1115 waiver authority is effective, children who opt to take up premium assistance under FHIAP and Healthy Kids ESI are not subject to Title XXI cost sharing rules. These children are subject to cost sharing rules through ESI plans. Healthy KidsConnect children are subject to the 5% cap.

8.1.2. ☒ NO, skip to question 8.8.
CHIP OHP Plus children have no cost sharing requirement.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: **Member premiums will be a maximum of 10% of the overall premium for members over 200 up to and including 250% of the FPL. Member premiums will be a maximum of 15% of the overall premium for members over 250 up to and including 300% of the FPL. Members will be sent an enrollment confirmation letter at the time of initial plan enrollment and each eligibility redetermination. This notice will include, but is not limited to monthly premium, the member's premium cost and the state paid portion. The notice will also include the maximum cost-sharing allowed for the family, including premiums, co-insurance and copayments and will clearly state that the carrier will track the out of pocket costs. Under Express Lane Eligibility when a child is found eligible for HKC which require premiums, the Department sends a notice informing the client that the child may be eligible for lower or no premiums using our regular eligibility methods. If a child were found to be ineligible using an ELE finding the Department would do a full eligibility determination.**

8.2.2. Deductibles: **None**
8.2.3. Coinsurance or copayments:
Coinsurance or copayments: Each carrier will offer one or two plan options, described as follows:
Option A has a combination of copayments and coinsurance. Each benefit or service will have either a copayment or coinsurance percentage associated with it. In no case will there be both a copayment and coinsurance applied to the benefit.
Option B has copayments only for each benefit or service.
8.2.4. Other: **Medical out of pocket maximums are the same for both Options A & B: $900 for families with 1 child and $1800 for families with 2 or more children. Prescription out of pocket maximum is the same for both options A&B: $100 for families with 1 child and $200 for families with 2 or more children; Dental out of pocket maximums are also the same: families with 1 child are $200 and families with 2 or more children are $400. In no case will total out of costs exceed 5 percent of the family's annual income.**

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b)) **Benefits and cost-sharing information will be available to the public through the Office of Healthy Kids website at: www.oregonhealthykids.gov as well as the Office of Private Health Partnerships website: www.oregon.gov/ophp. Outreach and marketing materials will also include the information. Additionally, Oregon Administrative Rules will reference the HKC benefits and cost sharing. The rule filing process includes public notification in writing, public advisory committee review, rule posting on the agency website and a public feedback hearing prior to rule implementation. As indicated in sec 8.2.1 Members will receive an enrollment confirmation letter at the time of initial plan enrollment and each eligibility redetermination. This notice will include, but is not limited to monthly premium, the member's premium cost and the portion paid by OPHP. The notice will also include the maximum cost-sharing allowed for the family, including premiums, co-insurance and copayments and will clearly state that the carrier will track the out of pocket costs.**

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR

457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

During the first contract year the carriers' premiums were not adjusted to reflect the cost share cap of 5%. Therefore the state will employ one or more of the following three methods to ensure enrollees do not exceed the yearly 5% out of pocket maximum:

(1) The state will establish an arrangement with each carrier to track copayments and coinsurance. DHS will provide OPHP with income information (used for eligibility determination) for each family. This will give OPHP the basis for the family's 5 percent threshold.

OPHP will then calculate the 5 percent maximum for each family approved for Healthy KidsConnect using the family's annual income. The state will subtract the family's yearly premium share from this amount. The difference between the 5% maximum and the yearly premium share will be the family's net liability for cost sharing. Using this calculation, OPHP will determine which enrolled families might exceed their 5% maximum.

The state and carrier will then establish a mechanism to track actual coinsurance and copayments. Oregon will require that all carriers work to ensure that claim payment systems are updated in real time, so that out of pocket costs are not exceeded inadvertently. Carriers will send OPHP a regular accounting of actual family out of pocket costs for tracking purposes;

(2) Insurers will include the enrollee cost sharing maximum in their actuarial calculations and adjust premium costs to account for the increased risk;

(3) The state will adjust subsidy levels to offset the enrollee cost sharing limits.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
DHS will provide a PERC code to identify members of a Federally recognized Indian tribe. the carrier systems will be adjusted to ensure that the identified children pay no out of pocket costs or premiums subject to 42 CFR 457.535.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

The strategic objective for Oregon's Children's Health Insurance Program (CHIP) is to expand coverage of the Oregon Health Plan (OHP) to include eligible low income children. The current OHP delivery system assures quality medical care to the Medicaid and CHIP population by removing financial barriers and providing access to inpatient, outpatient, primary and preventive health care services. Specific strategic objectives include:

Objective 1 Expand OHP eligibility rules to include uninsured children:

- **Birth through age 5. Living in households with gross income between 133% and 200% of the federal poverty level (FPL) .**

Age 6 through 18. Living in households with two months average gross income between 100% and 200% of the FPL.

Objective 2 Identify CHIP eligibles through coordinated and ongoing outreach activities.

Objective 3 Enroll CHIP eligibles in the OHP Plus, FHIAP ESI, Healthy Kids ESI or Healthy KidsConnect health care delivery system to assure a usual source of health care coverage.

Objective 4 Monitor access and utilization patterns among DHS CHIP OHP Plus and Healthy KidsConnect enrollees.

Objective 5 Improve the health status of CHIP enrollees through provider and client programs specific to the needs of this population.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

The following performance goals and measures will be utilized to measure the effectiveness of Oregon's identified strategic objectives for CHIP:

Performance Goals for Objective 1
Since July 1, 1998, the Division of Medical Assistance Programs (DMAP)

has expanded the capacity of the OHP to meet the needs of 48,000 CHIP eligibles. DMAP's data and operational systems are structured to accommodate CHIP criteria in the areas of eligibility determination, enrollment, client information, and utilization of health care services. DMAP staff and Department of Human Services (DHS) field personnel have and continue to receive CHIP-related training.

Performance Goals for Objective 2
Since January 1, 1999, DMAP has developed and implemented outreach efforts among current Medicaid OHP channels to identify, enroll, and meet the health care needs of the CHIP population.

Performance Goals for Objective 3
As of May 2009, 48,000 low income children are enrolled in Oregon's CHIP. They have access to a usual source of health care coverage in the form of a stable health care plan and a primary care provider (PCP).

Performance Goals for Objective 4
DHS CHIP enrollees are assigned a unique code that will enable DMAP analysts to distinguish CHIP clients from the OHP Medicaid population. DMAP monitors CHIP utilization patterns to help assure access to health care and the delivery of medically appropriate care.

Performance Goals for Objective 5
Health status and health care system measures for Oregon's DHS CHIP program enrollees are collected and analyzed to demonstrate acceptable utilization in the following areas: access to a primary care provider, childhood immunization status, and well-child and -adolescent visits.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))
Oregon's performance relative to its stated goals is objectively and independently verified through DMAP analysis of DHS CHIP population and utilization data. The ongoing analysis of data obtained through the Medicaid Management Information System (MMIS) is used to measure the state's progress toward its goals and objectives.

As previously noted, health plan oversight occurs as clinical data review, desktop medical chart audits, and on-site inspection of PHPs.

Health plans are notified when areas of deficiency are discovered and of corrective actions needed. PHPs are required to give DMAP medical and dental service utilization reports, provider capacity reports and access to service statistics and various semiannual and annual financial reports. In addition to administering client satisfaction surveys, DMAP produces monthly enrollment reports, quarterly disenrollment reports and reports profiling the demographic characteristics of enrollees.

DMAP staff directly responsible for the implementation and monitoring of CHIP, continuously monitor program administration and take necessary action to ensure the program meets strategic objectives.

The Office for Oregon Health Policy and Research will analyze and evaluate the implementation of the Healthy Kids, including FHIAP Healthy Kids ESI, CHIP OHP Plus and Healthy KidsConnect expansion. The office will report on information using a variety of data sources including a statewide health insurance survey, program administrative data and other quantitative and qualitative data sources. Unless otherwise noted, the program will be evaluated annually.

- **Biennial estimates of the number of children who are eligible for but not enrolled in the program;**
- **The number of children enrolled in the program;**
- **The number of children disenrolled from the program;**
- **A description of any identified barriers to enrolling or maintaining enrollment of children in the program;**
- **The quality of care received using nationally accepted HEDIS measures for children;**
- **Biennial estimates of the number children voluntarily not enrolling in employer-sponsored health coverage and enroll in the program.**

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well childcare
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☐ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)
Oregon provides an annual report to the Secretary, as required. The report includes evaluation of CHIP program components, coordination with other state-sponsored health insurance programs and an evaluation of the progress made toward increasing health insurance coverage for children in Oregon.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
Policy guidance for the development of Oregon's response to Title XXI includes substantial public comment and participation. The Oregon Legislature established the Oregon Health Council as the body responsible for providing a forum for public debate on the policy framework for the state's CHIP program. The Health Council is the

policy-recommending body for health planning in the state. It consists of nine public members appointed by the Governor. The Health Council held a public hearing on Oregon's response to CHIP on October 18, 1997 in Salem, Oregon. At this meeting, approximately 30 interested parties, including consumers and consumer advocates, providers, managed care plans, insurance carriers, and educators, delivered testimony. Besides this focused, three-hour public hearing, the Health Council also solicited public comment at its regular meetings. At each of the six Council meetings held September 1997 through January 1998, written and oral public comment about CHIP was provided and discussed. On January 15, 1998, there were four additional public hearings around the state; Portland and Eugene in the Willamette Valley, Medford in Southern Oregon, and Bend in Central Oregon. Approximately 70 additional parties presented testimony at these hearings. There were comments on both general program policy issues and the proposed administrative rules for the Family Health Insurance Assistance Program (FHIAP). Program staff then summarized this public input and presented to a joint meeting of the Health Council and the Insurance Pool Governing Board that will oversee the operations of the FHIAP program. DMAP staff was also represented at this meeting, because Oregon is attempting to ensure consistent policies for the two complementary programs, the state-funded FHIAP commercial health insurance subsidy program and the CHIP program. Additional opportunities to receive public input around CHIP design and implementation have occurred and continue. A draft of the initial Title XXI State Plan document was circulated for comment internally to state agencies and externally to providers, consumer advocates, and to a broad array of other interested parties. When the original Title XXI State Plan was submitted to CMS, DMAP submitted a notice for publication in Oregon's major newspapers. All interested Oregonians were notified on how to obtain a copy of this document and had timely opportunity to comment on CHIP

Oregon Health Decisions conducted a series of approximately 200 meetings around the state. "Health Decisions '98" continued ongoing efforts by Oregon Health Decisions to engage Oregonians at the grass-roots level in a democratic approach to developing health policy. A similar series of "town hall meetings" in 1990 informed the setting of health service priorities by the Health Services Commission, information upon which they developed the Prioritized List of Health Services. A subsequent set of focus groups in 1995 addressed questions designed to identify the most sensible "next steps" for the Oregon Health Plan following implementation of the Medicaid expansion with benefits based on those priorities. "Health Decisions '98" focused on issues of how we

finance health care, who ultimately pays for it, and how we can build more equity into the financing of health care while improving access and quality. As in the past with the Oregon Health Plan, public input on CHIP and more general health care policy questions is being used to inform debate, set policy, and develop concepts for program development and proposed legislation. Public comment is a continuing part of Oregon's design, implementation, and refinement of its CHIP program and other expansions of the Oregon Health Plan.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

The Department engages Tribal consultation prior to submission of state plan amendments, waiver requests, proposed demonstration waivers, and rule-making likely to have a cost or direct impact on Oregon Native Americans, Indian Health Programs, or Urban Indian Organizations. To the extent practical and permitted by law, the state consults with Tribal governments as early as possible in the consultation process. This policy applies to the Children's Health Insurance Program in the same manner in which it applies to Medicaid.

A representative from the Division of Medical Assistance Programs attends quarterly "770" meetings to discuss proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have a direct impact on American Indians and Tribal entities. Face-to-face consultation is the preferred method of communication and consultation prior to submission of documents to the Centers for Medicare and Medicaid Services. In the event a deadline is out of the control of the Division, the communication and consultation will be handled by mail distributed through the Department Tribal Liaison to Tribal designees. A monthly written Division of Medical Assistance Program Update is also provided to the DHS Tribal Liaison, who forwards it to Tribal designees. This update includes the status of State Plan Amendments, waiver or demonstration project proposals or amendments, and rule filings.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d). **Prior to an amendment being submitted, DHS coordinates with the Oregon Health Policy Committee and Tribal organizations, Medicaid Advisory Committee or Legislative Committees as appropriate. Oregon Administrative Rules are filed and at a minimum DMAP gives a public notice 45 days prior to any changes or closure of the program .**

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Budget included as an attachment

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1. ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections *(Sections 2101(a))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

12.1. Eligibility and Enrollment Matters

Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

DHS CHIP applicants and members have the same rights as OHP Medicaid members with respect to eligibility and enrollment matters. Clients and applicants have a right to a timely, written, impartial external review through the administrative hearing process that complies with 42 CFR 457.1120.

Under Express Lane Eligibility when a child is found eligible for HKC which require premiums, the Department sends a notice informing the client that the child may be eligible for lower or no premiums using our regular eligibility methods. If a child were found to be ineligible using an ELE finding the Department would do a full eligibility determination.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

DHS CHIP members have the same rights as OHP Medicaid members with respect to denials, reductions and termination of services. Clients have a right to a timely, written, impartial external review through the DMAP administrative hearing process that complies with 42 CFR 457.1120. Additionally Healthy KidsConnect plan are regulated by private insurance rules which also guide how insurance appeals and grievances are handled,.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.