OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR 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 (SCHIP). 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.

Form CMS-R-211

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: Bruce Goldberg — Position/Title:Director Oregon Department of Human Services

Name: James Edge — Position/Title: Administrator Division of Medical Assistance

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 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, N2-14-26, Baltimore, Maryland 21244.

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 Office 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)**:
Initial SCHIP State Plan
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 SCHIP 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
Implementation date: October 1, 2004

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

State Plan Amendment # 7: Unborn child expansion
Submitted : July 27, 2007
Approved:
Effective date: April 1, 2008
Estimated Implementation date: April 1, 2008

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

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 S-CHIP, 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 table below compares number of uninsured children by Federal Poverty Level (FPL).

	<100%	100-133%	134-150%	151-185%	186-200%	>200%
Age 0-5 Total	44,545	18,900	9,736	24,500	10,500	146,862
Age 0-5 insured	40,719	16,375	8,435	21,465	9,199	139,784
Age 0-5 uninsured	3,826	2,525	1,301	3,035	1,301	7,078
Age 6-11 Total	40,781	18,697	9,632	20,872	8,547	187,063
Age 6-11 insured	35,490	14,180	7,305	17,198	6,972	179,785
Age 6-11 uninsured	5,290	4,516	2,327	3,674	1,574	7,278
Age 12-18 Total	47,577	21,813	11,237	24,595	9,971	218,241
Age 12-18 insured	41,406	16,544	8,523	20,065	8,134	209,749
Age 12-18 Uninsured	6,172	5,269	2,714	4,531	1,837	8,491

Sources: 1996 Oregon Population Survey, Portland State University Center for Population Research and Census.

The primary source of health coverage for most children is an employer-based policy, most often sponsored by a parent's employer. Employer-based coverage accounts for 82 percent of all children's health insurance coverage in the state, while public sources make up 13 percent and the remaining 5 percent is from other sources. Nearly 60 percent of all children in Oregon (519,000) live within a Metropolitan Statistical Area (MSA), with the remainder living in more rural areas of the state. There are striking differences in the rates of health care coverage within these two areas.

	Insured	**Uninsured**
Inside MSA 59% 519,000	**95% 490,000**	**5% 29,000**
Outside MSA 41% 350,000	**88% 310,000**	**12% 40,000**

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):

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 applications and application assistance are available at the 64 Adult and Family Services (AFS) branch offices throughout the state and at 56 Senior and Disabled Services field offices. A well-publicized 800 number to the OHP Medicaid Application Center is also available. The Application Center mails applications on request and helps callers in completing OHP applications and related forms. There is also an 800 number to an Interactive Voice Response system where applicants can check on the status of their applications. Brochures outlining the services and eligibility requirements and containing the Application Center toll-free number 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 services, eligibility requirements and processes is also available on the DMAP website.

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 applications and to give on-site assistance with completion of the OHP application for pregnant women and their families. Currently DMAP has 140 outreach sites located throughout the state.

Hospital Hold
If an uninsured patient is admitted to a hospital, the hospital may fax a Hospital Hold form for the patient to the OHP Medicaid 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 program application although they cannot physically reach a phone or a DHR branch. An OHP Medicaid application is sent to the patient. For those who complete and return the application and are determined eligible for OHP Medicaid, their eligibility is retroactive to the date of request. The original date of request is honored if the application is received within 30 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 hotline, designed to link low-income Oregon residents with health care services within their communities, including information on the Oregon Health Plan.

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:

The Family Health Insurance Assistance Program (FHIAP) is administered by the Insurance Pool Governing Board (IPGB). FHIAP is a health insurance premium assistance program, which pays from 70 to 95 percent of the insurance premium. Eligibility is based on family size and income. Applicants to the FHIAP program also receive informational materials about the Oregon Health Plan Medicaid and SCHIP programs.

Another component of the overall Oregon Health Plan is the Oregon Medical Insurance Pool (OMIP), Oregon's high risk health insurance program. The 1987 Oregon Legislature established OMIP which is operated by the Department of Consumer and Business Services. The program began offering coverage July 1990. It provides health benefits coverage to Oregonians who are unable to obtain individual health benefits due to health reasons.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP 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-SCHIP:

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, SCHIP and the Family Health Insurance 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 Services, Office of Family Health Services

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 SCHIP, 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 includes the toll free telephone number for the application center and other materials about the Oregon Health Plan Medicaid and SCHIP 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))**

Health care services for S-CHIP clients are 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 S-CHIP enrollees for a monthly capitated payment. The Office 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 16 Fully Capitated Health Plans (FCHPs), 7 Dental Care Organizations (DCOs), and thirteen 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). As part of OHP Medicaid 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.

S-CHIP enrollees have the same choice of managed care plans as OHP Medicaid enrollees in their area. S-CHIP clients are required to enroll in a FCHP, a DCO, a MHO, and, in Deschutes County only, a CDO, as a condition of eligibility. If no managed care plan is available, the S-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, S-CHIP clients are not be required to enroll in a managed care plan and receive services on a fee for service basis. In service areas where DCO capacity is limited, S-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 S-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 is working with the Oregon Dental Association and client advocates to develop strategies to encourage more pediatric dentists to practice in Oregon, including encouraging the reestablishment of a pediatric dentistry residency at Oregon Health Sciences University.

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))**

DMAP's quality assurance rules and quality improvement review process require participating 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 required under S-CHIP to ensure S-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 nonemergent 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 S-CHIP services provided on a FFS basis, all utilization review requirements of Title XIX and the 1115 Demonstration apply. The Oregon Medical Peer Review Organization 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.

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: **Entire state of Oregon, with additional unborn expansion pilot in Multnomah County (possible phase in to other counties).**

4.1.2. ☒ Age: **Birth to age 19, except for pilot in Multnomah County (with possible phase in to other counties) which is Conception to Birth.**

4.1.3. ☒ Income:
Birth to six, family income of 133% FPL to 170% FPL, ages to19, family income 100% FPL to 170% FPL. Average of three months income evaluated. 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. Pilot population: 0% of the FPL (and not eligible for Medicaid) through 185% of the FPL.

4.1.4. ☒ Resources (including any standards relating to spend downs and disposition of resources):
No more than $10,000 in liquid assets, defined as cash, checking accounts, savings accounts, time certificates, stocks, bonds, IRAs, securities or other assets that can be changed for cash.

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 SCHIP unless the applicant is a member of a 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 a 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:
Not covered by other creditable health coverage, other than OHP/ Medicaid, for at least six months before application, with some exceptions. There is an exception to this rule for children with life-threatening or disabling conditions.

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 six-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 program.

4.1.8. ☒ Duration of eligibility**:**
Redetermination every twelve months for State Plan children (<185% FPL)
No limit to duration of eligibility if all conditions are met. The Pilot Multnomah County (with possible phase in to other counties)

population unborn, is eligible for SCHIP benefits while in utero and redetermined at birth.

4.1.9. ☒ Other standards (identify and describe):
Although eligibility is retroactive to date of S-CHIP application, the client is not eligible if the application does not include selection of a prepaid health plan in mandatory managed care areas. This is the same as the current rule applied to OHP Medicaid non-categorical members.

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 SCHIP 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 are also available from DHS branch offices and designated outreach facilities. Applicants are informed of the Medicaid and SCHIP 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 SCHIP 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 Medicaid is 6 months. The eligibility period for SCHIP is 12 months.

To continue benefits after one's eligibility period (Medicaid: 6 months; SCHIP: 12 months), the applicant needs to reapply for benefits. To facilitate continuous health care coverage for eligible children, the OHP application processing center sends a notice and a new application to enrollees notifying

them that their coverage is scheduled to end soon. Enrollees receive a total of three notices before coverage is terminated.

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 SCHIP program is currently funded to cover 19,744 children (State Plan Amendment December 12, 2000). This number represents average enrollment. Because of high turnover in the program, DMAP will close the program to new enrollment when enrollment reaches approximately 22,000 children. DHS will notify the public that the program is temporarily closing. Applicants who apply during the closure period will receive notification that the program is temporarily closed and a phone number to call for up-to-date information on program status. Due to the complexity and changes in family income, DHS will not maintain a waiting list for the program.

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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

Oregon uses one application for SCHIP 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. Applicants are informed of the Medicaid and SCHIP 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 SCHIP 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 Medicaid is 6 months. The eligibility period for SCHIP 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 are eligible for private coverage are not enrolled in SCHIP.

To continue benefits after one's eligibility period (Medicaid: 6 months; SCHIP: 12 months), the applicant needs to reapply for benefits. To facilitate continuous health care coverage for eligible children, the OHP application processing center sends a notice and a new application to enrollees notifying them that their coverage is scheduled to end soon. Enrollees receive a total of three notices before coverage is terminated. In addition, children enrolled in the S-CHIP program are instructed to notify the program in the event they become pregnant, in which case will move them 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 S-CHIP when that year is up, and to apply for the S-CHIP program.**

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 SCHIP 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 SCHIP 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. Applicants are informed of the Medicaid and SCHIP 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 SCHIP 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 Medicaid is 6 months. The eligibility period for SCHIP is 12 months.

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.

DMAP has specific measures to prevent the clients from substituting SCHIP coverage for group health coverage. The first measure is that persons covered by private health insurance are not eligible for benefits under SCHIP. Another measure to prevent substitution is that children are ineligible if they have been covered by a group health plan six months immediately preceding the application for SCHIP. There are exceptions to the 6-month rule 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 SCHIP as a measure to avoid substitution for group health coverage. 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 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 six-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 belonging to employees of State government of Oregon are not eligible for SCHIP coverage since the State provides coverage of dependants.

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 eligible for private coverage are not enrolled in SCHIP. **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.

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.

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

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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 tribes in the state, the PAIHB and the Portland Indian Health Service. S-CHIP has been and continues to be a recurring agenda item at these meetings. S-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 S-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 S-CHIP will be incorporated into existing OHP Medicaid outreach activities, including:

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

These programs are described in more detail in Section 2.2.1

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
- 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)

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).** *When any grouping below is provided only if medically necessary and/or limited to emergency and periodontal for the Unborn pilot it is identified with *L/MN.

Section	Benefit description	Eligibility Groups covered by the state plan	Conception to birth Pilot
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	☒	☒*L/MN

or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

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-funded abortion services are available to SCHIP**

6.2.17. Dental services **(Section 2110(a)(17))** ☒ ☒*L/MN

6.2.18. Inpatient substance abuse treatment services ☒ ☒
*L/MN
and residential substance abuse treatment services **(Section 2110(a)(18))**

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))** ☐ ☐

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))** ☒ ☐

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))**

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 fee-for-service. In addition, access to primary care provider and measures of early childhood cavities prevention efforts are measured.

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))**

As described in Section 3.1, S-CHIP services will be provided through Oregon's existing OHP Medicaid Demonstration delivery system. 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 S-CHIP. This assures S-CHIP 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 S-CHIP members are conducted within the context of ongoing DMAP quality improvement and evaluation efforts. As described in DMAP's

Oregon Health Plan Administrative Rules and the General Rules, Prepaid Health Plans (PHPs) that contract with the state 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 S-CHIP 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 recordkeeping 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 S-CHIP 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 70 percent of OHP-SCHIP 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 Care 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 DMAP and/or MHDDSD. 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 S-CHIP. 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.**

Two PHPs that currently contract with DMAP have NCQA accreditation. 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. American 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 biannual member satisfaction survey using the nationally standardized CAHPS instrument to assess member's experiences of access, satisfaction, and system performance.

Quality Assurance and Utilization Review

Oregon will build on the successful design, implementation, and improvement of the OHP Quality Improvement Program for S-CHIP. PHPs will 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 Department of Human Resources, the Oregon 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 Medicaid plans, the Oregon 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 Oregon 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 will develop programs to help prevent children and adults from starting to use tobacco and will increase 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.

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))**

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.**

7.2.2 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))**

PHPs are required to assure access to the services it provides 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 DMAP or MHDDSD, as applicable, that the plan has surveyed and monitored for equal access of DMAP Members to referral providers pharmacy, hospital, vision and ancillary services;

7.2.3 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))**

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.

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
8.1.2. ☒ NO**, skip to question 8.8.**

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:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

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))**

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))**

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)**

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 assist in the purchase, in whole or in part, for coverage that abortion (except as described above). **(Section (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 State 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 Medicaid delivery system assures quality medical care to the S-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 to age 5. Living in households with three months average gross income between 133% and 170% of the federal poverty level (FPL) and liquid assets amounting to less than $10,000.
- Age 6 to 18. Living in households with three months average gross income between 100% and 170% of the FPL and liquid assets amounting to less than $10,000.

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

Objective 3 Enroll S-CHIP eligibles in the OHP health care delivery system to assure a usual source of health care coverage.

Objective 4 Monitor access and utilization patterns among S-CHIP enrollees.

Objective 5 Improve the health status of S-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 S-CHIP:

Performance Goals for Objective 1
By July 1, 1998, the Office of Medical Assistance Programs (DMAP) will expand the capacity of the OHP to meet the needs of 17,000 S-CHIP eligibles. DMAP's data and operational systems will be structured to accommodate S-CHIP criteria in the areas of eligibility determination, enrollment, client information, and utilization of health care services. DMAP staff and Department of Human Resource (DHR) field personnel will receive S-CHIP-related training.

Performance Goals for Objective 2
By January 1, 1999, DMAP will develop and implement outreach efforts among current Medicaid OHP channels to identify, enroll, and meet the health care needs of the S-CHIP population.

Performance Goals for Objective 3
By July 1, 1999, 17,000 low income children will be enrolled in Oregon's S-CHIP. They will have access to a usual source of health care coverage in the form of a stable health care plan and an assigned primary care provider (PCP).

Performance Goals for Objective 4
By July 1, 1998, S-CHIP enrollees will be assigned a unique code that will enable DMAP analysts to distinguish S-CHIP clients from the OHP Medicaid population. DMAP will monitor S-CHIP utilization patterns to help assure access to health care and the delivery of medically appropriate care.

Performance Goals for Objective 5
By July 1, 1999, the following health status and health care system measures for Oregon's S-CHIP enrollees will be 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 will be objectively and independently verified through DMAP analysis of S-CHIP population and

utilization data. The ongoing analysis of data obtained through the Medicaid Management Information System (MMIS) will be 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 S-CHIP continuously monitor program administration and take necessary action to ensure the program meets strategic objectives.

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 child care
- 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:
  Access to PCP

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 S-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 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 S-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 S-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 S-CHIP program. Additional opportunities to receive public input around S-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 S-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 S-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 S-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))**

See section 4.4.5

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).

As noted in section 4.3.1, Oregon has a cap on S-CHIP enrollment. Because the number of children enrolled in SCHIP is not expected to trigger a closure in enrollment within the next twelve months (June 30, 2003), as of the date of this revised state plan, DMAP has not yet submitted this policy for public comment. DMAP will give public notice at least 45 days prior to closure.

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.

See attached

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**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that

complies with 42 CFR 457.1120.

Applicants and SCHIP 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.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with **42 CFR 457.1120.**

SCHIP 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.

Premium Assistance Programs

12.3 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