DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

June 7, 2024

Vivian Levy
Interim Medicaid Director
Oregon Health Authority
500 Summer St NE, E35
Salem, Oregon 97301

Dear Director Levy:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Oregon's Basic Health Program (BHP) Blueprint, submitted on April 18, 2024. This certified Blueprint permits Oregon to establish a BHP and received federal funds in its BHP trust fund, with coverage beginning July 1, 2024.

The BHP Blueprint contains sufficient information to determine that the BHP will comply with the requirements of section 1331 of the Affordable Care Act (ACA) and 42 CFR Part 600. The Blueprint demonstrates adequate planning for the integration of BHP with other insurance affordability programs in a manner that will permit a coordinated experience for potentially eligible individuals seeking coverage in any of the programs. The Blueprint is also a complete and comprehensive description of the BHP and its operations, demonstrating thorough planning and a concrete program design.

On July 1, 2024, Oregon will transition individuals with income 138-200% federal poverty level (FPL) who are enrolled in the state's section 1115(a) demonstration titled "Oregon Health Plan" (Project Number 11-W-00415/10) and who meet the BHP eligibility criteria to the BHP. The state will also begin accepting applications for the BHP. Individuals enrolled in qualified health plans (QHPs) through the Federally-facilitated Marketplace (FFM) will not be automatically transitioned to the BHP but will have their eligibility redetermined when they update their Marketplace applications.

As you know, Oregon plans to enroll lawfully present non-citizens with income 0-138% FPL, who would otherwise be eligible for the BHP pursuant to 42 CFR 605.305(a)(2), in the state-funded Healthier Oregon Program (HOP). HOP is currently under review for minimum essential coverage (MEC) recognition and is awaiting approval from CMS's Center for Consumer Information and Insurance Oversight. If Oregon is unable to obtain MEC recognition for HOP, the state will be out of compliance with federal BHP regulations in 42 CFR 600.305(a)(2), and the state will then need to allow individuals enrolled in HOP to enroll in the BHP if eligible.

Oregon is using its Medicaid Coordinated Care Organizations (CCOs) to offer BHP standard health plans. Given the nature of the CCO model, Oregon has indicated that for most regions of the state, only one CCO is available to BHP enrollees. CMS approves the state's exception to 42 CFR 600.420(a)(i) - (iii), which requires the state to offer a choice of standard health plan offerors to the BHP enrollees, for calendar year 2024. If Oregon needs this exception for subsequent calendar years, it must submit this request on an annual basis through a Blueprint revision.

Your BHP Project Officer is Carrie Grubert. Carrie is available to answer your questions concerning this revision and other BHP-related matters. Carrie's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8319
E-mail: Carrie.Grubert@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone Director

Basic Health Program Blueprint

Introduction

Section 1331(a) of the Affordable Care Act directs the Secretary to establish a Basic Health Program (BHP) that provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage.

States choosing to operate a BHP must submit this BHP Blueprint as an official request for certification of the program.

States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace. A state that open a BHP will receive federal funding equal to 95 percent of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals, using a methodology set forth in a separate funding protocol based on a methodology set forth in companion rulemaking.

Given the population served under BHP, the program will sit between Medicaid and the Marketplace, and while states will have significant flexibility in how to establish a BHP, the program must fit within this broader construct and be coordinated with other insurance affordability programs. Regulations for the BHP were finalized on March 12, 2014 and are available at https://www.medicaid.gov/basic-health-program/index.html.

The BHP Blueprint is intended to collect the design choices of the state and ensure that we have a full understanding of the operations and management of the program and its compliance with the federal rules; it is not intended to duplicate information that we have collected through state applications for other insurance affordability programs. In the event that a State seeks to make a significant change(s) that alter program operations described in the certified Blueprint, the state must submit a revised Blueprint to the Secretary for review and certification.

The BHP Blueprint sections reflect the final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and Secretarial oversight relating to BHP.

Acronyms List

BHP	Basic Health Program
CHIP	Children's Health Insurance Program
CSR	Cost Sharing Reduction
ESI	Employer Sponsored Insurance
EHB	Essential Health Benefits
FPL	Federal Poverty Level
IAP	Insurance Affordability Program
MEC	Minimum Essential Coverage
OMB	Office of Management and Budget
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SHP	Standard Health Plan

Section 1: Basic Health Program-State Background Information

State Name: Oregon

Program Name (if different than Basic Health Program): Basic Health Program

BHP Blueprint Designated State Contact:

Name: Vivian Levy
Title: Interim Medicaid Director
Phone: 503 400-1976
Email: Vivian.Levy@oha.oregon.gov

Requested Initial Interim Certification Date (if applicable): Pick date.

Requested Initial Full Certification Date: 5/1/2024

Requested Initial Program Effective Date: 7/1/2024

Blueprint Revisions:

Revision number	Summary	Effective date	Certification date
Enter text	Enter text.	Pick date	Pick date
Enter text	Enter text	Pick date	Pick date
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Administrative agency responsible for BHP ("BHP Administering Agency"):

Oregon Health Authority

BHP State Administrative Officers:

Position	Title	Location (Agency)	Responsible for:
Enter text.	Enter text.	Enter text.	Enter text.
Enter text.	Enter text.	Enter text.	Enter text.
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Program Administration: (Management, Policy, Oversight)

Position	Title	Location (Agency)	Responsible for:
Dave Baden	Deputy Director for Policy and Program	Oregon Health Authority	Oversight
Vivian Levy	Interim Medicaid Director	Oregon Health Authority	Management
Ali Hassoun	Interim Health Policy and Analytics Division Director	Oregon Health Authority	Policy development
Leann Johnson	Division of Equity and Inclusion Director	Oregon Health Authority	Equity and inclusion
Ebony Clark	Behavioral Health Director	Oregon Health Authority	Behavioral health policy
Nate Singer	Oregon Eligibility Program Director	Oregon Department of Human Services	Management of eligibility and enrollment

Program Administration: (Contracting, Eligibility Appeals, Coverage Appeals)

Position	Title	Location (Agency)	Responsible for:
Dave Inbody	CCO Operations Director	Oregon Health Authority	Benefit operations and administration, contract negotiations, appeals
Nikki Olson	Interim Deputy Medicaid Director	Oregon Health Authority	Eligibility policy, service delivery and benefits policy
Jillian Johnson	Oregon Eligibility Partnership Interim Deputy Director	Oregon Department of Human Services	Eligibility and enrollment operations and administration
Chere LeFore	Oregon Eligibility Partnership Oversight, Quality Assurance and Central Coordination Administrator	Oregon Department of Human Services	Quality Assurance & Oversight
	Enter text.	Enter text.	Enter text.

Finance: (Budget, Payments)

Position	Title	Location (Agency)	Responsible for:
Janell Evans	Interim Chief Financial Officer	Oregon Health Authority	Budget
Chelsea Guest	Office of Actuarial and Financial Analysis Director	Oregon Health Authority	Actuarial analysis and rate development
Gregory Tooman	Manager of Office of Forecasting, Research and Analysis	Oregon Health Authority	Forecasting
Shawn Jacobsen	Deputy Controller – Financial Operations	Oregon Department of Human Services	Financial operations

Position	Title	Location (Agency)	Responsible for:
Enter text.	Enter text.	Enter text.	Enter text.

Governor or Designee: Vivian Levy

Signature: /Signed by Vivian Levy/

Date of Official Submission: April 18, 2024

Section 2: Public Input

TO BE COMPLETED FOLLOWING PUBLIC INPUT

This section of the Blueprint records the state's method for meeting the public comment process required for Blueprint submission. This section applies only to the current Blueprint submission.

Date public comment period opened: 5/1/2023

Date public comment period closed: 7/1/2023

Please describe the public comment process used in your state, such as public meetings, legislative sessions/hearing, the use of electronic listservs, etc.:

Oregon posted the draft 1331 Basic Health Program Blueprint on the state website (Oregon.gov) on the "Helping Oregonians Maintain Coverage After the Public Health Emergency Ends" page at the following link: https://www.oregon.gov/oha/PHE/Pages/phe-maintain-coverage.aspx . The notice was also recorded on the Secretary of State page in the Oregon Records Management Solution for the May 2023 notice. The state utilized five listservs to reach members of the community across the state, the HIMAC, Markeptlace, 1115 waiver, OHP Providers and OHP Other Stakeholders listservs. The OHP Provider Updates and OHP Stakeholders lists include provider organizations and associations, Coordinated Care Organizations (CCOs), individual providers, licensing boards, community partners, and state and county contacts. Together these lists reached over 34,000 people. The state held two public hearings on May 9 hosted by the Oregon Health Authority and May 31 hosted by the Medicaid Advisory Committee. Both meetings were recorded and both the recordings and all meeting materials were shared on the website listed above.

Provide a list below of the groups/individuals that provided public comment:

- Adapt Integrated Health Care
- American Lung Association
- Asher Community Health Center
- Cambia Health Solutions
- CareOregon
- Cascadia Health
- Central City Concern
- Columbia River Health
- Committee to Protect Health Care
- HIV Alliance
- Kaiser Permanente
- La Clinica
- LaPine Community Health Center
- Members of the public (8)
- Members of the Medicaid Advisory Committee (4)
- Mosaic Community Health
- Multnomah County
- Multnomah County Health Department
- Nehalem Bay Health Center and Pharmacy
- Neighborhood Health Center
- Northwest Human Services
- Oregon Academy of Family Physicians (OAFP)

- Oregon Dental Association
- Oregon Nurses Association
- Oregon Primary Care Association (OPCA)
- Oregon State Public Interest Research group (OSPIRG)
- PacificSource
- Rogue Community Health
- SEIU Local 49
- The Leukemia & Lymphoma Society (LLS)
- The Main Street Alliance
- Virginia Garcia Memorial Health Center
- Wallace
- Waterfall Community Health Center
- Winding Waters
- Yamhill Community Care
- Yakima Valley Farm Workers Clinic

If the state has federally recognized tribes, list them below. Provide an assurance that they were offered consultation and note if comments were received.

Federally Recognized Tribes in Oregon	State agency solicited input (Indicate with an "X" if input was solicited)	Input received (Indicate with an "X" if input was received)
Burns Paiute Tribe	☒	☐
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians	☒	☐
Confederated Tribes of Grand Ronde	☒	☐
Confederated Tribes of Siletz Indians	☒	☐
Confederated Tribes of the Umatilla Indian Reservation	☒	☐
Confederated Tribes of Warm Springs	☒	☐
Coquille Indian Tribe	☒	☐
Cow Creek Band of Umpqua Tribe of Indians	☒	☐
Klamath Tribes	☒	☐

Provide a brief summary of public comments received and the changes made, if any, in response to public comments:

Oregon received 42 written comments, 36 in support, 5 against, and 1 neutral. All verbal comments were neutral questions asking for more information or context. Common themes from the written comments included:

- General support for the BHP
- Support for expanding BHP coverage up to 400%
- Support for a state-based marketplace
- Support for value-based payment and increasing provider reimbursement
- Concerns regarding increased costs for marketplace members
- Concern regarding communications and administrative burden related to mid-year launch

No edits were made to the blueprint based on public comments received.

Section 3: Trust Fund

Please provide the BHP Trust Fund location and relevant account information.

Similar to our accounting of other federal funds, and consistent with state law, the BHP funds will be contained in a separate and distinct fund that rolls up to the state's appropriated fund 6400 (the state's legislatively mandated segregation of funds based on the source of revenue – for this purpose federal funds) as well as a separate grant. Funds will be deposited and expended out of the agency's treasury account listed and named below.

Additional expenditure and revenue codes will be established in order to meet the requirements of OMB A-87, A-133, and 45 C.F.R. Part 75. The BHP funding will be segregated within its distinct fund and would not be comingled with other funding.

Institution:

Oregon Health Authority

Address:

500 Summer Street, NE, E-20 Salem, OR 97301-1097

Phone Number:

503-947-2340

Account Name:

OHA Bridge Plan Fund

Account Number:

Click or tap here to enter text.

Trustees

Name	Organization	Title	May authorize withdrawals? (Indicate with an "X" if named individual can authorize withdrawals)
Dave Baden	Oregon Health Authority	Deputy Director for Policy and Program	☒
Vivian Levy	Oregon Health Authority	Interim Medicaid Director	☒
Janell Evans	Oregon Health Authority	Budget Director	☒
Kris Kautz	Oregon Health Authority	Chief Operations Officer	☒
Shawn Jacobsen	Oregon Department of Human Services	Deputy Controller – Financial Operations	☒

Is anyone other than Trustees indicated above able to authorize withdrawals?

No

If yes, please include the name and title of everyone with this authority.

Name	Organization	Title
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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If there is separation between the entity holding the trust fund ("Trustees") and the entity operating the trust fund, please describe the relationship below. Include the name, and contacts for the entity operating the trust fund. Also include a copy of a written agreement outlining the responsibilities of the entity operating the trust fund.

Name	Organization	Title	Contact
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Please name the CMS primary contact for the BHP trust fund and provide contact information.

CMS Primary Contact Name: Click or tap here to enter text.

CMS Primary Contact Phone: Click or tap here to enter text.

CMS Primary Contact Email: Click or tap here to enter text.

Please describe the process of appointing trustees:

The named appointees are assigned as trustees on the basis of their current positions within OHA. Based on existing procedures and the way the state oversees all financials, including federal funds, the appropriate lead fiscal representatives were named as Trustees for the BHP Fund. This allows the state to follow the same procedures, review, and oversight as is conducted for other state related business.

Provide a list of all responsibilities of Trustees:

The Trustees are assigned based on their current positions within OHA. The Trustees all go through extensive review, interviews, and minimum qualification assessments prior to being hired into their positions. Therefore, all Trustees listed have significant financial responsibility within the state and have the qualifications to make decisions related to this matter. Trustees provide oversight to ensure that all fund expenditures are made in an allowable manner. In addition, trustees will specify individuals with authority to make withdrawals from the fund to make allowable expenditures.

Has the state made any arrangements to insure or indemnify trustees against claims for breaches of fiduciary responsibility?

Yes

If yes, what are they?

Because the Trustees are appointed based on their current employment positions within OHA, they are indemnified against claims of breaches in fiduciary responsibility under Oregon Statutes 30.285.

Trust Fund Attestation	**Attest that the Agency is immediately ready and able.** (Indicate with an "X" to signal attestation.)	**Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)**
The BHP Administering Agency will:		
600.710(a) Maintain an accounting system and fiscal records in compliance with Federal requirements for state grantees, including OMB circulars A-87 and A-133 and applicable federal regulations.	☒	Click or tap to enter a date.

Trust Fund Attestation	Attest that the Agency is immediately ready and able. (Indicate with an "X" to signal attestation.)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
600.710(b) Obtain an annual certification from the BHP Trustees, the State's CFO, or designee, certifying the state's BHP Trust Fund FY financial statements, and certifying that BHP trust funds are not being used for the non-federal share for any Federally funded program, and that the use of BHP trust funds is otherwise in accordance with Federal requirements (including that use of BHP funds is limited to permissible purposes).	☒	Click or tap to enter a date.
600.710(c) Conduct an independent audit of Trust Fund expenditures over a 3-year period in accordance with chapter 3 of GAO's Government Auditing Standards.	☒	Click or tap to enter a date.
600.710(d) Publish annual reports on the use of funds within 10 days of approval by the trustees.	☒	Click or tap to enter a date.
600.710(e) Establish and maintain BHP Trust Fund restitution procedures.	☒	Click or tap to enter a date.
600.710(f) and (g) Retain records for 3 years from the date of submission of a final expenditure report or until the resolution and final actions are completed on any claims, audit or litigation involving the records.	☒	Click or tap to enter a date.

Section 4: Eligibility & Enrollment

This section of the Blueprint records the state's choices in determining eligibility procedures for BHP and records assurances that demonstrate comportment with BHP standards. The state must check all pertinent boxes and fill in dates where applicable.

Please name the agency with primary responsibility for the function of performing eligibility determinations: Oregon Health Authority

Attestation	**Completed** (Indicate with an "X" to signal completion)	**If No, Expected Completion Date (mm/dd/yyyy)**	**Marketplace Policy** (Indicate with an "X" if Marketplace Policy applies)	**Medicaid Policy** (Indicate with an "X" if Medicaid Policy applies)
Eligibility Standards				
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.	☐	7/1/2024	N/A	N/A
305(a)(1) Resident of the State.	N/A	N/A	N/A	N/A
305(a)(2) Citizen with household income exceeding 133 but not exceeding 200% FPL or lawfully present non-citizen ineligible for Medicaid or CHIP due to immigration status with household income below 200% FPL.	☐	7/1/2024 Note: When the BHP launches, Oregon intends to continue covering lawfully present non-citizens 0-138% FPL via Healthier Oregon	N/A	N/A
305(a)(3) Not eligible to enroll in MEC or affordable ESI.	N/A	N/A	N/A	N/A
305(a)(4) Less than 65 years old.	N/A	N/A	N/A	N/A
305(a)(6) Not incarcerated other than during disposition of charges.	N/A	N/A	N/A	N/A
Application Activities				
310(a) Single streamlined application includes relevant BHP information.	☐	7/1/2024	N/A	N/A
310(b) Application assistance, including being accessible to persons who are limited English proficient and persons who have disabilities consistent with 42 CFR435.905(b), is equal to Medicaid.	☒	Click or tap to enter a date.	N/A	N/A

Attestation	Completed (Indicate with an "X" to signal completion)	If No, Expected Completion Date (mm/dd/yyyy)	Marketplace Policy (Indicate with an "X" if Marketplace Policy applies)	Medicaid Policy (Indicate with an "X" if Medicaid Policy applies)
310(c) State is permitting authorized representatives; indicate which standards will be used.	☒	Click or tap to enter a date.	☐	☒
315 State is using certified application counselors; indicate which standards will be used.	☒	Click or tap to enter a date.	☐	☒
Eligibility Determinations and Enrollment				
320(c) Indicate the standard used to determine the effective date for eligibility.	☐	7/1/2024	☒	☐
320(d) Indicate the enrollment policy used in BHP (the open and special enrollment periods of the Exchange OR the continuous enrollment process of Medicaid).	☐	7/1/2024	☐	☒
335(b) Indicate the standard used for applicants to appeal an eligibility determination.	☐	7/1/2024	☐	☒
340(c) Indicate the standard used to redetermine BHP eligibility.	☐	7/1/2024	☐	☒
345 Indicate the standard to verify the eligibility of applicants for BHP.	☐	7/1/2024	☐	☒

Note: N/A = Not applicable; indicates that there are no choices available.

1. Please indicate whether the state will implement continuous eligibility and redetermine enrollees every 12 months as long as enrollees are under 65, not enrolled in alternative MEC and remain state residents.

   Yes

   If no, please explain redetermination standards. (These standards must be in compliance with 42 CFR 600.340(f).)

   Click or tap here to enter text.

2. Please list the standards established by the state to ensure timely eligibility determinations. (These standards must be in compliance with 42 CFR 435.912 exclusive of 435.912(c)(3)(i)).

The integrated ONE system is designed with several automations to ensure timely eligibility determinations. For example, tasks are automatically assigned a priority level, which impacts the order in which tasks are worked by staff. Task priority levels are defined by levels 1 thru 3, with level 1being the highest priority and 3 being the lowest. Tasks can change in priority depending on the case status and timelines. For example, new application tasks created for individuals without benefits are a P1. Tasks related to renewals begin at a P3 but move up in priority (and therefore the task queue) closer to the renewal date. Each task is also automatically assigned a due date and will move up in priority as it gets closer to the due date. Written requests for information (RFI) are also automatically assigned a due date to provide sufficient time for individuals to respond and for the agency to process the response in order to meet the processing timeframe requirements.

In addition to task logic, ONE is programmed to automatically run eligibility and authorize benefits in several situations, including but not limited to:

- Deny/discontinue medical when information requested has not been received by the due date (RFI and missing information batches)
- Deny medical when it is dependent on a long-term care request and a valid service record has not been received by the 45th day
- Reasonable compatibility income verification used for MAGI and non-MAGI programs

3. Please describe the state's process and timeline for incorporating BHP into the eligibility service in the state including the State's Marketplace (if applicable). Include pertinent timeframes and any contingencies that will be used until system changes (if necessary) can be made.

Oregon's eligibility system (ONE) determines eligibility for a variety of benefit programs, including Medicaid, TANF cash assistance, SNAP, and more. BHP eligibility will be incorporated into this system as a new eligibility category for health benefits delivered by the Oregon Health Plan. The ONE system is already capable of determining Medicaid eligibility for people who apply for health insurance coverage through the state's health insurance Marketplace and would similarly determine BHP eligibility for these individuals.

Oregon is making modifications to existing eligibility and enrollment systems and Medicaid Management Information System (MMIS) to enable Eligibility determination for OHP Bridge to occur alongside existing Medicaid eligibility determinations beginning July 1, 2024. Once system changes are fully implemented on June 26th, , all applicants will be simultaneously evaluated for eligibility for Medicaid, OHP Bridge (BHP), and state-funded coverage options.

Prior to full implementation of system changes, Oregon will issue manual notices to people who will move directly from Medicaid to OHP bridge to alert them of their coverage change and comply with federal advance notice requirements for Medicaid. Upon the full implementation of the system changes, people will receive additional information confirming their new coverage or, if they are ineligible for OHP Bridge, informing them of their ineligibility and their rights to appeal such decisions.

If system changes are not implemented prior to July 1, 2024, the state has the ability to delay the full implementation of OHP Bridge and keep individuals identified as moving to the program instead enrolled in Medicaid until system changes are fully implemented.

4. Please describe the process the state is using to coordinate BHP eligibility and enrollment with other IAPs in such a manner as to ensure seamlessness to applicants and enrollees.

Oregon will coordinate BHP eligibility and enrollment procedures with the Marketplace in the same manner as the state currently does for Medicaid coverage.

In addition, Oregon intends to implement the BHP in July 2024 in a manner that will minimize mid-year coverage disruptions of people who are already enrolled in Marketplace plans for the 2024 plan year. In order to accomplish this, Oregon will not require BHP-eligible individuals enrolled in Marketplace coverage to enroll in the BHP. BHP-eligible individuals who remain in Marketplace plans for the remainder of 2024 will not face financial penalties in the form of Premium Tax Credit recoupment, as confirmed by CMS and Treasury. Oregon proposes the following to accomplish this goal:

1. People enrolled in Oregon's temporary Medicaid expansion category covering people with income in the BHP eligibility range will be automatically moved to the BHP July 1, 2024, with eligibility verified using information gained during the individual's post-PHE unwinding redetermination.

    a. Oregon will use income eligibility verification gained during post-PHE unwinding member redeterminations wherein an individual is determined eligible for the Temporary Medicaid Expansion program to start a 12-month continuous eligibility period. If the Temporary Medicaid Expansion program ends prior to an individual's 12-month continuous eligibility period, the individual will be entitled to BHP eligibility for the remainder of the 12-month continuous eligibility period. This would ensure that individuals receive the same 12-month continuous eligibility protections they would receive if Oregon had implemented the BHP immediately upon the start of the post-PHE unwinding redeterminations process.

    b. People in this category who are determined not eligible for BHP (e.g., because of affordable offer of ESI or income change), would be disenrolled from 1115 Medicaid waiver population and shifted to appropriate coverage.

2. Beginning July 1, 2024, Oregon will accept applications for BHP coverage through existing application portals and any new BHP eligible applicants will go through eligibility determination and be enrolled in the BHP if determined eligible.

3. Individuals with existing Marketplace coverage will have the option, starting July 1, 2024, to apply for BHP coverage. Those determined eligible for the BHP would be enrolled in the BHP and have their Marketplace coverage terminated in the same manner as if they moved from Marketplace coverage to Medicaid.

4. Marketplace enrollees who had been determined ineligible for government-sponsored minimum essential coverage (MEC) for 2024 and who do not actively update their applications after the BHP is implemented in 2024 will remain enrolled in their current Marketplace coverage (QHP) through the remainder of plan year 2024. Marketplace enrollees who do not actively update their applications for plan years 2025 and/or 2026 (and who have opted into automatic reenrollment) will be automatically redetermined ineligible for government-sponsored MEC (including BHP) for the year(s) in which they are passively reenrolled. All Marketplace enrollees who are determined ineligible for government-sponsored MEC for a given plan year (and thus are enrolled in Marketplace coverage with APTC) will remain eligible for APTC for that plan year and will be treated as ineligible for government-sponsored

MEC for the purposes of determining PTC eligibility. Other PTC rules (e.g., obligation to file a return and reconcile APTC, household income calculations, caps on excess APTC repayment) would continue to apply equally to the same extent as they would to other Marketplace enrollees.

One of the primary goals in Oregon's implementation of a BHP is to reduce churn and improve continuity of coverage for people who regularly enroll and disenroll in Medicaid. The above enrollment structure is critical to minimizing any mid-year coverage disruptions that could occur among people already enrolled in Marketplace plans and who do not actively choose to enroll in the BHP. This structure is further is necessary the Federally Facilitated Marketplace does not have the ability to automatically move someone off their Marketplace plan and into the BHP.

5. If the state is submitting a transition plan in accordance with 600.305(b), please describe the transition plan in the box below. The plan must include dates by which the state intends to complete transition processes and convert to full implementation.

Section 5: Standard Health Plan Contracting

This portion of the Blueprint collects information about the service delivery system that will be used in the state as well as how the state plans to contract within that system.

Delivery Systems

1. Please assure that standard health plans from at least two offerors are available to enrollees. ☐

2. If applicable, please describe any additional activities the state will use to further ensure choice of standard health plans to BHP enrollees.

Not applicable

3. If the state is not able to assure choice of at least two standard health plan offerors as described in question 1, please attach the state's exception request. This exception request must include a justification as to why it cannot assure choice of standard health plan offeror and demonstrate that it has reviewed its competitive contracting process in accordance with 42 CFR 600.420(a)(i) - (iii).

To ensure continuity of coverage and care for people 0-200%FPL, the Oregon Basic Health Program will be administered by Coordinated Care Organizations (CCOs), Oregon's Medicaid managed care entities. A CCO is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive Medicaid coverage. The CCO model therefore promotes local organizations collaborating with one another as opposed to fostering competition. Accordingly, while some regions of the state have more than one CCO, most do not. The most populous areas of the state have more than one CCO, and thus while most regions of the state have a single CCO, nearly half of all Medicaid members are in areas with CCO choice. Because Oregon seeks to capitalize on the success of the CCO model, the state is proposing to utilize the existing CCO network and requests an exception to 42 CFR 600.420(a)(i) - (iii). Oregon will revisit the availability of additional plans when the state undergoes its next procurement cycle.

4. Is the state participating in a regional compact?

   No

   IF YES, please answer questions 5 - 9. If no, please skip questions 5 - 9.

5. Please indicate the other states participating in the regional compact.

N/A

6. Are there specific areas within the participating states that the standard health plans will operate? If yes, please describe.

N/A

7. If a state contracts for the provision of geographically specific standard health plans, please describe how it will assure that enrollees, regardless of location within the state, have choice of at least two standard health plan offerors. Please indicate plans by area.

N/A

8. Please assure that the regional compact's competitive contracting process complies with the requirements set forth in 42 CFR 600.410. ☐

9. If applicable, please indicate any variations in benefits, premiums and cost sharing, and contracting requirements that may occur as a result of regional differences between the participating regional compact states.

N/A

Contracting Process

States must respond to all of the following assurances. If the state has requested an exception to the competitive process for 2015, the State is providing the following assurances with regard to how it will conduct contracting beginning in program year 2016.

The State assures that it has or will:

(These are mandatory elements. Each box below must be checked to approve Blueprint.)

	Assurance: (Indicate with an "X" to signal assurance)
Conducted the contracting process in a manner providing full and open competition including:	
45 CFR 92.36(b) Following its own **procurement standards** in conformance with applicable federal law.	☒
45 CFR 92.36(c) Conducting the procurement in a manner providing **full and open competition.**	☒
45 CFR 92.36(d) Using **permitted methods** of procurement.	☒
45 CFR 92.36(e) Contracting with **small, minority and women owned firms** to the greatest extent possible.	☒
45 CFR 92.36(f) Providing a **cost or price analysis** in connection with every procurement action.	☒
45 CFR 92.36(g) Making available the **Technical specifications for review**.	☒
45 CFR 92.36(h) Following policies for **minimum bonding requirements.**	☒
45 CFR 92.36(i) Including all the **required contract terms** in all executed contracts.	☒
Included a negotiation of the following elements:	
Premiums and cost sharing. **(N/A)**	☐
Benefits.	☒
Innovative features, such as:	
Care coordination and care management	☒
Incentives for the use of preventive services	☒
Maximization of patient involvement in health care decision making	☒
Other (specify below) Click or tap here to enter text.	☐
Meeting health care needs of enrollees.	☒
Included criteria in the competitive process to ensure:	
Local availability of and access to providers to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area so that access to services is **at least sufficient** to meet the standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235.	☒

	Assurance: (Indicate with an "X" to signal assurance)
Use of managed care or a similar process to improve the quality accessibility, appropriate utilization and efficiency of services provided to enrollees.	☒
Development and use of performance measures and standards.	☒
Coordination between other Insurance Affordability Programs.	☒
Measures to address fraud, waste and abuse and ensure consumer protections.	☒
Established protections against discrimination including:	
Safeguards against any enrollment discrimination based on pre-existing condition, other health status related factors, and comply with the nondiscrimination standards set forth at 42 CFR 600.165.	☒
Established a Medical Loss Ratio of at least 85% for any participating health insurance issuer.	
The minimum standard is reflected in contracts	☒

Standard Health Plan Contracting Requirements

States are required to include the standard set of contract requirements that will be incorporated into its Standard Health Plan contracts. Please reproduce in the text box below. Standard Health Plan contracts are required to include contract provisions addressing network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, and provisions protecting the privacy and security of personally identifiable information. However, we have given states a "safe harbor" option of reusing either approved Medicaid or Exchange contracting standards. If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

Medicaid contracting standards will be used.

Coordination of Health Care Services

Please describe how the state will ensure coordination for the provision of health care services to promote enrollee continuity of care between BHP and Medicaid, CHIP, the Exchange and any other state administered health insurance programs.

Oregon's decision to deliver the Basic Health Program through the same managed care plans that serve Medicaid/CHIP members (called Coordinated Care Organizations, or CCOs) is designed to ensure continuity of care for enrollees moving between Medicaid/CHIP and the BHP. Using the same health plans will enable people to move seamlessly between programs when income fluctuates without actually navigating a change in plan enrollment or needing to identify new providers or sources of care. This decision is being made in order to accomplish one of Oregon's key policy objectives related to the BHP, which is to reduce churn and improve continuity of care for people leaving Medicaid.

Oregon will utilize a variety of strategies to ensure continuity of care when people move between the BHP and Marketplace-based coverage, based on how Oregon currently works to facilitate transitions between Medicaid and the Marketplace and on the state's strategies to connect people leaving Medicaid to Marketplace plans during the unwinding of federal continuous coverage provisions.

During the redetermination process, Oregon is performing extra work to connect people leaving Medicaid to a Marketplace plan that includes providers they regularly have used in the preceding 12-months. Oregon will examine claims/utilization data on members leaving Medicaid and being directed to the Marketplace to identify their regular sources of care. The Marketplace is working with an outside vendor that provides eligibility processing and call center support to determine which Marketplace plans include the providers that they've used in the last year, and would then identify the lowest cost silver plans that include these providers. Oregon intends to duplicate this strategy to the extent possible upon the implementation of the BHP. Oregon has additionally been working with community-based organizations and partner agents who provide equity-focused outreach and enrollment assistance that focuses on the unique needs of members from communities that disproportionately experience social and health inequities.

Oregon's use of the HealthCare.gov Marketplace platform limits the state's ability to directly transfer complete member account files (that include pre-populated applications) between systems. For instance, while Marketplace enrollees who become eligible for the BHP when going through the open enrollment process may have complete information transferred directly to Oregon's ONE eligibility system that will process BHP applications, Oregon is not able to transfer complete information to HealthCare.gov in a manner that establishes a Marketplace application for members. Oregon will seek to add this capability to any state-based marketplace technology

that is considered in future years.

Section 6: Premiums and Cost-sharing

This section of the Blueprint collects information from the state documenting compliance with requirements for establishing premiums and cost-sharing. Additionally, it provides CMS general information about the states planned premium and cost sharing structures and administration.

Premiums

Premium Assurances

The State assures that (check all that apply):

☒ The monthly premium imposed on any enrollee does not exceed the monthly premium the individual would have been required to pay had he/she been enrolled in the applicable benchmark plan as defined in the tax code.

☒ When determining premiums, the State has taken into account reductions in the premium resulting from the premium tax credit that the enrollee would have been paid if he/she were in the Exchange.

☒ It will make the amount of premiums for all standard health plans available to any member of the public either through posting on a website or upon request. Additionally, enrollees will be notified of premiums at the time of enrollment, reenrollment or when premiums change, along with ways to report changes in income that might affect premiums.

Please provide the web address or other source for public access to premiums.

Web Address:

N/A

Other Source:

N/A – Oregon will not charge monthly premiums for members enrolled in the Basic Health Program

Please describe:

1. The group(s) of enrollees subject to premiums, including any variation by FPL, and the applicable premiums.

No members will be subject to monthly premium to enroll in the BHP

2. The collection method and procedure for the payment of premiums.

No premiums will be collected

3. The consequences for an enrollee or applicant who does not pay a premium, including grace periods and re-enrollment procedures.

N/A – no monthly premiums

Cost-Sharing

Cost-Sharing Assurances

The State assures that (check all that apply):

☒ Cost sharing imposed on enrollees meets the standards imposed by 45 CFR 156.420(c), 45 CFR 156.420(e), 45 CFR 156.420(a)(1) and 45 CFR 156.420(a)(2).

☒ Cost sharing for Indians meets the standards of 45 CFR 156.420(b)(1) and (d).

☒ The State has not imposed cost sharing for preventive health services or items as defined in accordance with 45 CFR 147.130.

☒ The State has provided the amount and type of cost-sharing for each standard health plan that is applicable to every income level either on a public website or upon request to any member of the public, and specifically to applicants at the time of enrollment, reenrollment or when cost-sharing and coverage limitations change, along with ways to report changes in income that might affect cost-sharing amounts.

Please provide the web address or other source for public access to cost-sharing rules.

Web Address:

Click or tap here to enter text.

Other Source:

N/A – no co-payments or other cost sharing will be charged to BHP enrollees

Please describe:

1. The group(s) subject to cost sharing.

No groups will be subject to cost sharing

2. All copayments, co-insurance, and deductibles, by service.

No co-payments, co-insurance, or deductibles will apply to any service.

3. The system in place to monitor compliance with cost-sharing protections described above.

N/A – no cost sharing in program

Disenrollment Procedures for Non-Payment of Premiums

N/A

Has the state elected to offer the enrollment periods equal to the Exchange defined at 45 CFR 155.410 and 420?

Choose Yes or No

If yes, check the box on the right to indicate the state assures that it will comply with the premium grace periods standards at 45 CFR 156.270 prior to disenrollment and that it will not restrict reenrollment beyond the next open enrollment period. ☐

If no, check the box on the right to indicate the state assures that it is providing a minimum grace period of 30 days for the payment of any required premium prior to disenrollment and that it will comply with reenrollment standards set forth in 457.570(c). ☐

If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is:

Enter number of days.

Section 7: Operational Assessment

The State assures that it can or will be able to:

	Full Assurance (Indicate with an "X" to signal assurance)	**Contingent Assurance** (Indicate with an "X" to signal assurance)
Eligibility and Renewals		
Accept an application online, via paper and via phone and provide in alternative formats in accordance with 42 CFR §600.310(b).	☒	☐
Return an accurate and timely eligibility result for all BHP eligible applicants.	☐	☒
Process a reported change and redetermine eligibility.	☒	☐
Comply with the ex-parte renewal process.	☒	☐
Issue an eligibility notice and share such notice with CMS.	☒	☐
Issue a renewal notice and share such notice with CMS.	☒	☐
Ability to terminate/disenroll from BHP for a variety of reasons, such as reaching age 65, obtaining MEC.	☒	☐
Issue termination/disenrollment notice to enrollees.	☒	☐
Benefits and Cost-Sharing [N/A]		
Exempt American Indians from Cost-sharing.	☐	☐
Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing limits.	☐	☐
Premium Payment and Plan Enrollment		
Issue an accurate and timely premium invoice. [N/A]	☐	☐
Receipt and apply the premium payment correctly. [N/A]	☐	☐
Notify enrollee of health plan choices and complete plan enrollment.	☒	☐
Issue a health plan disenrollment notice.	☒	☐
Coordinate enrollment with other Insurance Affordability Programs		
Transfer accounts and provide notification in accordance with 42 CFR 600.330(c) through (e).	☒	☐

Contingency Descriptions

Please describe the contingency or dependency that limit full assurance.

Oregon's assurance that it will return timely eligibility results is contingent on eligibility workforce staffing and staffing of appropriate office and training supports. Oregon is currently undergoing a substantial eligibility redetermination of all Medicaid enrollees to unwind federal continuous eligibility provisions in place since early 2020. Although Oregon has been experiencing longer-than-normal timelines for eligibility determination that cannot be processed electronically, more than 91% of Medical applications submitted in January & February 2024 were evaluated in a timely manner.

Oregon is additionally implementing two-year continuous Medicaid eligibility, which will alleviate some of the workload currently placed on Oregon Health Authority and Oregon Department of Human Services staff. However, because preliminary enrollment forecasts suggest that Oregon will not reduce to pre-pandemic Medicaid enrollment, additional staffing will be needed to support the new Basic Health Program enrollment process. Both agencies have requested funding from the legislature for additional staff for this purpose.

In the first two years of full BHP implementation, Oregon's ability to return timely eligibility determinations for all new applicants may also be dependent on timely receipt of individuals' information from Healthcare.gov for people previously enrolled in marketplace plans who will instead move to the BHP. Oregon will work with CMS to ensure appropriate data can be transferred to ensure a timely eligibility determination for people coming directly from Marketplace coverage.

Note that Oregon's indication of contingent assurance regarding returning an accurate and timely eligibility result for all BHP applicants is with respect to timeliness, not accuracy. Oregon will rely on the ONE system to develop the BHP eligibility system, which will ensure accuracy.

Please describe any mitigation steps that will be in place and the date by which a full assurance will be possible.

Oregon will be implementing systems changes in 2024 to prepare for implementation on July 1, 2024. Oregon cannot provide a date for full assurance until after the PHE-unwinding is complete currently planned for February, 2025.

Section 8: Standard Health Plan

This final section of the BHP Blueprint is a benefits description that allows a state to define the standard health plan(s) that will be offered under the BHP. The standard health plan is the set of benefits, including limitations on those benefits for which a state will contract. States are required by statute to offer the Essential Health Benefits (EHB) that are equally required in the Marketplace. States are also required to define those benefits using any of the base-benchmark or reference plans set forth at 45 CFR 156.100 (which could be a different base-benchmark or reference plan than is used for Marketplace or for Medicaid purposes). The benefits description below maps the base-benchmark plan to the EHB categories.

The Blueprint will not be a complete submission without the benefits description below defining the standard health plan offered under BHP.

Standard Health Plan

State Name: Oregon

Transmittal Number: Click or tap here to enter text.

Benefits description

The state is proposing to use a CMS approved EHB based plan based on the Alternative Benefit Plan developed for the Oregon Health Plan.

Choose Yes or No.

State Name: Oregon

Benefits Description
The state is proposing to use a CMS approved EHB based plan. ☐ Yes ☒ No **Benefits Included in Standard Health Plan** Enter the specific name of the base benchmark plan selected: PacificSource Preferred CoDeduct Value 3000 35 70

☒ Essential Health Benefit 1: Ambulatory patient service	
Benefit Provided: Physician services	Source: State Plan 1905(a)
Authorization : Other	Provider Qualifications: Medicaid State Plan
Amount Limit: None	Duration Limit None

Scope Limit:

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

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

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

Benefit Provided:
Nurse Practitioner

Source:
State Plan 1905(a)

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

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

Benefit Provided:
Chiropractor

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

Benefit Provided:
Family Planning

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

Benefit Provided:
Podiatrist services (OLP)

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Optometrist services (OLP)

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Tobacco cessation

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Outpatient hospital

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Hospice

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
90 day period with subsequent 60-day periods

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

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

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

☒ Essential Health Benefit 2: Emergency services

Benefit Provided:
Outpatient hospital services

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Emergency-Physician services

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Emergency-medical transportation-outpt hsp

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

☒ Essential Health Benefit 3: Hospitalization

Benefit Provided:
Inpatient hospital

Source:
State Plan 1905(a)

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

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

Benefit Provided:
Physician-inpatient hospital

Source:
State Plan 1905(a)

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Some procedures or services may require a prior authorization such as transplants; MRI; bariatric surgeries, etc. The Physician is responsible to obtain the authorization for the procedure. No authorization required for emergency services.

☒ Essential Health Benefit 4: Maternity and newborn care

Benefit Provided:
Maternity care-Physician services

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Maternity care-Nurse practitioner

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

Benefit Provided:
Maternity care-Nurse Midwife

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

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

Benefit Provided:
Inpatient hospital-MH/SUD

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

These hospital services are acute care hospitals and are not an IMD.

Benefit Provided:
Outpatient hospital-MH/SUD

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

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

Benefit Provided:
Physician services -MH/SUD

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Nurse practitioner -MH/SUD

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

☒ Essential Health Benefit 6: Prescription drugs

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

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

Authorizations:	Provider Qualifications:
☒ Yes	State Licensed

☒ Limit on days supply
☐ Limit on number of prescriptions
☐ Limit on brand drugs
☐ Other coverage limits
☒ Preferred drug list

Coverage that exceeds the minimum requirements or other:

☒ Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Benefit Provided:
Inpatient hospital- Rehabilitative

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Rehabilitative - these services are acute care hospitals and are not an IMD.

Benefit Provided:
Outpatient hospital- Rehabilitative

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided: Source:
Physical,speech & occupational therapy- Reh/Hab State Plan 1905(a)

Authorization : Provider Qualifications:
Other Medicaid State Plan

Amount Limit: Duration Limit
None None
Scope Limit:
Services provided within the scope of practice as defined under state law.

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

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

Benefit Provided: Source:
Home health- Reh/Hab State Plan 1905(a)

Authorization : Provider Qualifications:
Other Medicaid State Plan

Amount Limit: Duration Limit
None None

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

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

Service authorization varies, this benefit includes DME, PT,OT, speech services provided in a home setting. Services and limits per plan of care, some services require authorization, limits can be exceeded when medically necessary.

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

Authorization : Provider Qualifications:
Other Medicaid State Plan

Amount Limit: Duration Limit
None None

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

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

Some prosthetic devices require prior authorization. These include but are not limited to lumbar orthotics, spinal orthotics, orthopedic shoe, shoulder-elbow orthotics. Limits can be exceeded when medically necessary.

Benefit Provided:
Eyeglasses

Source:
State Plan 1905(a)

Authorization :
Prior Authorization

Provider Qualifications:
Medicaid State Plan

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

Duration Limit
Limits for non-pregnant adults age 21 and over

Scope Limit:

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

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

Limits to non-pregnant adults age 21 and over:
Routine vision services for the sole purpose of eyeglasses, are not covered. Coverage does include emergency eye exams and treatment and Non-emergency visual services with specific medical diagnoses.

Benefit Provided:
Dentures

Source:
State Plan 1905(a)

Authorization :
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits for age 21 and over

Duration Limit
Limits for age 21 and over

Scope Limit:

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

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

Dentures are used to replace, correct, or support a full or partial set of teeth. For ages 21 and older full dentures are limited to 1 every 10 years and partial dentures are limited to 1 every 5 years, exceptions are made when dentally appropriate.

Benefit Provided:
Nursing Facility Services-Skilled

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Level of care needs

Duration Limit
Level of care needs

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

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

Screening and assessment to determine level of care needs.

☒ Essential Health Benefit 8: Laboratory services

Benefit Provided:
Laboratory & X-ray

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

☒ Essential Health Benefit 9: Preventive and wellness services and chronic disease management

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

Benefit Provided:
Preventive services

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

☒ **12.** Base Benchmark Benefits Not Covered due to Substitution or Duplication

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

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) :
Primary care to treat illness/injury were bundled, along with specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services and nurse practitioner services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Specialist visits

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):
Specialist visits were bundled, along with Primary care to treat illness/injury and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services and nurse practitioner services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Outpatient Surgery

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):
Outpatient surgery were bundled, along with Primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a

duplication of physician services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Source:
Acupuncture Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Chiropractic Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Naturopath Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

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

Base Benchmark Benefit that was Substituted: Source:
Chemotherapy services Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Radiation therapy Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Sterilization Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:

Home health care — Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Telemedical services — Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Foot care — Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Medical contraceptives — Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

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

Base Benchmark Benefit that was Substituted: Emergency room-facility — Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

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

Base Benchmark Benefit that was Substituted: Source:
Emergency room-Physician Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Emergency medical transportation Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Bariatric surgery Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

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

Base Benchmark Benefit that was Substituted: Source:
Anesthesia Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s:

Breast reconstruction (non-cosmetic) services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a

duplication of inpatient hospital and physician-inpatient services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Source:
Blood transfusions Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:
Blood transfusions services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital and physician-inpatient services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Source:
Hospice/respite care Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:
Hospice / respite care services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the ''Ambulatory patient services' EHB category. The bundled services are a duplication of hospice services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Source:
Pre-& postnatal care Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:
Pre- & postnatal care services were bundled, along with Maternity services and mapped to the 'maternity and newborn care' EHB category. The bundled services are a duplication of maternity care-physician, maternity care-nurse practitioner, maternity care-nurse midwife services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s):
Delivery & inpatient maternity services were bundled, along with Maternity services and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s):
Inpatient hospital - mental/behavioral health services were bundled, and mapped to the 'Mental Health and substanse use disorder services, including behavioral health treatment' EHB category. The bundled

services are a duplication of Inpatient hospital-MH/SUD, physician-MH/SUD, nurse practitioner-MH/SUD, services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Detoxification Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Source:
Inpatient rehabilitation Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Durable medical equipment
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Prosthetics
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Orthotics
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Hearing aids
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Cochlear implants
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s):
Lab tests, x-ray services, & pathology were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

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

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

Base Benchmark Benefit that was Substituted: Source:
Genetic testing Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):
Genetic testing services were bundled and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Source:
Preventive services Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):
Preventive care services were bundled and mapped to the 'Preventive and wellness services and chronic disease management' EHB category. The bundled services are a duplication of Preventive services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s):
Smoking/Tobacco cessation program were bundled and mapped to the 'Ambulatory patient services' EHB category. The bundled services are a duplication of tobacco cessation sections from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Source:
Eyeglasses Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Dentures

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Skilled nursing

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Outpatient hospital

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Organ & tissue transplants

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s):

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

Base Benchmark Benefit that was Substituted: Newborn child coverage

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s:

Newborn services are billed separately through the newborn’s Medicaid ID, newborns will not be covered by BHP.

☒ Other Covered Benefits that are not Essential Health Benefits

Other Benefit Provided: Dental
Source: Medicaid Benefit Package

Authorization : Prior Authorization
Provider Qualifications: Medicaid State Plan

Amount Limit: Limits for age 21 and older
Duration Limit: None

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

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

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

Other Benefit Provided: Clinic services
Source: Medicaid Benefit Package

Authorization : None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

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

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

Other Benefit Provided: Non emergency medical transportation
Source: Medicaid Benefit Package

Authorization : Prior Authorization
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

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

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

Other Benefit Provided:
Extended services for pregnant women

Source:
Medicaid Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Other Benefit Provided:
Patient Cost in Qualifying Clinical Trails

Source: Medicaid Benefit Package

Authorization :
Yes

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

Other:

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Official Interim Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.

Full Certification:

Secretary/Secretary's Designee

/Signed by Sarah deLone/

Director
Center for Medicaid and CHIP services

Date of Official Full Certification: 6/7/2024

Implementation Date: 7/1/2024

Revised Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Revised Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.