DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

October 16, 2024

Emma Sandoe
Medicaid Director
Oregon Health Authority
500 Summer Street NE, E53
Salem, OR 97301

Dear Director Sandoe:

In accordance with section 1115(a) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) is approving Oregon's request to amend the demonstration titled "Oregon Health Plan (OHP)" (Project Number 11-W-00415/10 and 21-W-00073/10) (the "demonstration"), to provide expenditure authority for coverage of traditional health care practices. This approval is effective from October 16, 2024, through September 30, 2027, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

With this amendment, Oregon will have expenditure authority to provide coverage for traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization facilities). Coverage of these traditional health care practices will be available to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries who are able to receive services delivered by or through these facilities.

We are pleased to approve this amendment, which is part of a groundbreaking demonstration initiative that is expected to promote the objectives of Medicaid and CHIP by broadening the health coverage that can be furnished by states to Medicaid and CHIP beneficiaries who are able to receive services delivered by or through IHS, Tribal, and urban Indian organization facilities. This demonstration coverage is expected to be particularly impactful for American Indian and Alaska Native populations and individuals with physical or behavioral health needs because it is expected to improve their access to coverage of culturally appropriate health care. American Indian and Alaska Native traditional health care practices have historically been paid for and delivered by or through IHS, Tribal, or urban Indian organization facilities, but have not until now been covered or paid for by Medicaid or CHIP. Medicaid and CHIP payment for these services will promote access to care for American Indian and Alaska Native Medicaid and CHIP

beneficiaries and improve access to services at IHS, Tribal, and urban Indian organization facilities.

CMS's approval is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STC), and any supplemental attachment defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid and CHIP state plan requirements only to the extent those requirements have been identified in the attached expenditure authorities list as not applicable to expenditures under the amendment.

Section 1115(a) of the Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. This approval will permit CMS to evaluate the effects of providing Medicaid and CHIP coverage for these traditional health care practices, which cannot currently be covered under the Medicaid or CHIP state plans.

Extent and Scope of Demonstration Amendment

Background

Traditional health care practices are described by the World Health Organization as the "sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."[1] American Indian and Alaska Natives have long recognized the contribution of traditional healers and practitioners who are valued for their role in aiding the healing process. There are 574 federally recognized Tribes in the United States,[2] each with its own traditional health care practices. Some Tribes, bands, groups, pueblos, rancherias, nations, colonies, or communities, including Native villages or Native groups, see traditional health care practices as a fundamental element of health care that can help patients with specific physical and mental ailments.

American Indians and Alaska Natives experience significantly worse health disparities as compared to the general population, including higher incidence and prevalence of obesity, diabetes, tobacco addiction, and cancer. In addition to significant physical health issues, American Indians and Alaska Natives face mental health illnesses, substance use disorders, and suicide rates that impact Tribal communities at rates significantly higher than the general population.[3] A number of factors contribute to these persistent disparities, including barriers to

[1] https://www.who.int/health-topics/traditional-complementary-and-integrative-medicine#tab=tab_1. NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[2] https://www.usa.gov/tribes#:~:text=The%20federal%20government%20recognizes%20574,and%20learn%20how%20to%20enroll

[3] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

quality and timely medical care; geographic isolation; contemporary threats to culture, language, and lifeways; and lack of access to traditional foods.[4,5] However, several studies have demonstrated that traditional health care practices might help to improve mental health symptoms and outcomes and quality of life, including with respect to individuals with substance use disorder.[6,7,8] Section 1115 demonstrations can therefore further test the effects of providing coverage for traditional health care practices in Medicaid and CHIP.

The Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1601 *et seq*.) serves as one of the federal government's statutory authorities for IHS's provision of health care to American Indians and Alaska Natives and is based on the unique government-to-government relationship between the federal government and Indian Tribes. The United States Department of Health and Human Services promotion of traditional health care practices is authorized in the IHCIA at 25 U.S.C. 1680u.[9] Over the years, the provision of traditional health care practices has been supported primarily through IHS appropriations, Tribal resources, various pilot programs, and grant funding. Additionally, Medicaid is the largest source of third-party payment for services billed by IHS and Tribal facilities, accounting for nearly two-thirds of health coverage payments to these facilities.[10] Fifty-five percent of patients served by urban Indian organization facilities in 2021 had Medicaid or CHIP coverage.[11] Given the significant role of Medicaid as a payer for IHS, Tribal, and urban Indian organization facility services, authorizing Medicaid and CHIP payment to these facilities for traditional health care practices may potentially improve patient access to culturally appropriate practices to maintain and sustain health and otherwise support these facilities' ability to serve their patients.

As noted above, with this amendment, Oregon will have expenditure authority to provide coverage for traditional health care practices received through IHS, Tribal, or urban Indian organization facilities by Medicaid and CHIP beneficiaries who are able to receive services delivered by or through these facilities.[12] CMS expects that this amendment will broaden the

---

[4] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf
[5] https://minorityhealth.hhs.gov/american-indianalaska-native-health
[6] https://ncuih.org/research/third-party-billing/
[7] https://pubmed.ncbi.nlm.nih.gov/26851329/
[8] https://pubmed.ncbi.nlm.nih.gov/24842541/
[9] 25 U.S.C. 1680u specifically provides that "the Secretary may promote traditional health care practices, consistent with the [IHS] standards for the provision of health care, health promotion, and disease prevention under [title 25, chapter 18 of the U.S. Code]."
https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.
[10] Assistant Secretary of Planning and Evaluation (ASPE),
How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives, Report No. HP-2022-21, (Washington, DC, 2022),
https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf
[11] https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2021_UIO_UDS_Summary_Report_Final.pdf
[12] Whether a beneficiary is able to receive services from a qualifying facility will be determined by the applicable facility. Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are able (authorized) to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, urban Indian organization facilities

health coverage that can be furnished by states to these Medicaid and CHIP beneficiaries. The amendment is also expected to expand utilization of these traditional health care practices and improve access to culturally appropriate care; support these facilities' ability to serve their patients; maintain and sustain health; improve health outcomes and the quality and experience of care; and reduce existing disparities in access to and quality of care and health outcomes. This amendment also aligns with this Administration's policy priorities articulated in the 2022 guidance and implementation memorandum for Federal Agencies on recognizing and including Indigenous Knowledge in Federal research, policy, and decision making.[13] Furthermore, this approval supports the CMS Tribal Technical Advisory Group (TTAG) Strategic Plan 2020-2025 Objective 1C, Task 4, which states that CMS will support work to evaluate, use, and inform states on how the use of state plan amendments, section 1115 demonstrations, or other demonstrations can improve access for Tribal citizens and other IHS-eligible individuals to timely health care services.[14] Lastly, Medicaid and CHIP provide health coverage for approximately 35 percent of all American Indian and Alaska Native nonelderly adults and more than 60 percent of American Indian and Alaska Native children.[15] Given the scope of the American Indian and Alaska Native population covered by Medicaid and CHIP, this demonstration approval can play a key role in enhancing health equity for these populations.

Scope of Approval

Traditional health care practices vary widely by Tribe, facility, and geographic area. Under this amendment, traditional health care practices received through IHS, Tribal, or urban Indian organization facilities will be covered when provided to a Medicaid or CHIP beneficiary who is able to receive services delivered by or through these qualifying providers. Whether a beneficiary is able to receive services from a qualifying provider will be determined by the applicable provider. Purchased/referred care under 25 U.S.C. 1603(5) and 42 CFR 136.21(e) is included in this coverage. To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid and CHIP. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and

---

that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. Urban Indian organization facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds, such as those that are dual-funded by IHS and the Health Resources & Services Administration's Health Center Program. https://www.hrsa.gov/about/organization/offices/hrsa-iea/tribal-affairs/tribal-urban-indian-health-centers (including, for example, the urban Indian organization Native American Rehabilitation Association).

[13] https://www.whitehouse.gov/ceq/news-updates/2022/12/01/white-house-releases-first-of-a-kind-indigenous-knowledge-guidance-for-federal-agencies/

[14] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

[15] https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

CMS is also approving expenditure authority for administrative implementation expenditures to support provider development and implementation of this amendment, such as for accounting and billing systems; electronic health records and modifications to internal systems to accept referrals from other providers for these services; workforce development; and outreach, education, and community engagement.

Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under this approval, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid- and CHIP-covered services; and 3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per the STCs, the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under this approval when those services are received through IHS or Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[16] State expenditures for these services when delivered to Medicaid beneficiaries by

[16] Section 1905(b) of the Social Security Act (third sentence). Under CMS's longstanding interpretation of this statutory language, the 100 percent FMAP applies only when services are received through IHS and Tribal facilities by American Indian or Alaska Native Medicaid beneficiaries.

urban Indian organization facilities, state expenditures for these services when delivered by or through qualifying facilities to CHIP beneficiaries, and state expenditures for these services when delivered by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match. CMS will federally match state expenditures to support development and implementation of this amendment at the regularly applicable federal matching percentage for administrative expenditures. Oregon is approved to cover traditional health care practices for any Medicaid or CHIP beneficiary who is able to receive services delivered by or through IHS, Tribal facilities, or urban Indian organization facilities. Implementation of the amendment will be subject to the approval of the state legislature if the state is required to secure non-federal share for the expenditures authorized by this amendment.

As discussed in State Health Official letter #16-002, IHS facilities and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act "may enter into care coordination agreements with [non-IHS or Tribal] providers to furnish certain services for their patients who are [American Indian and Alaska Native] Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching…of 100 percent."[17]

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration, the "without waiver" (WOW) costs.

As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authority. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could

[17] https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS All-Inclusive Rate that is published annually in the Federal Register.[18] CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit of the demonstration (for more information on CMS's current approach to budget neutrality, see State Medicaid Director letter #24-003). Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.6. This amendment includes the addition of a "with waiver" only expenditure authority for implementation expenditures, which will be paid for with demonstration savings.

CHIP Allotment Neutrality

Under this amendment, the state will be subject to a limit on the amount of federal title XXI funding that the state may receive on allowable demonstration expenditures during the demonstration period. CMS has long required, as a condition of demonstration approval, that demonstrations be "allotment neutral," meaning the federal title XXI funds for the state's CHIP program are restricted to the state's available allotment and reallocated funds. The state is eligible to receive title XXI funds for allowable title XXI demonstration expenditures, up to the amount of its title XXI allotment. Title XXI funds must be first used to fully fund costs associated with CHIP state plan populations. The demonstration expenditures are limited to remaining funds. In requiring demonstrations to be allotment neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the CHIP program and its interest in facilitating state innovation and coverage through section 1115 demonstration approvals.

Requests Not Being Approved at this Time

CMS and Oregon will continue discussions regarding Oregon's request to convert the Special Diabetes Program for Indians to a Medicaid benefit.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust evaluation of the demonstration amendment in accordance with the STCs. In collaboration with CMS, the state must update its demonstration Monitoring Protocol to incorporate how it will monitor the amendment components, including relevant metrics data as well as narrative details describing progress with implementing the amendment.

[18] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

The state is required to incorporate the amendment into its evaluation to support a comprehensive assessment of whether the initiatives are effective in producing the desired outcomes for beneficiaries and the state's overall Medicaid program. Evaluation of the amendment is expected to assess beneficiary awareness and understanding of traditional health care practices; access to, utilization and cost of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. Additionally, the state's monitoring and evaluation efforts must facilitate understanding the extent to which the amendment might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

Oregon met the requirements for public notice for the demonstration application and CMS deemed the application complete. The state's public comment period for the OHP traditional health care practices request was held from December 1, 2021, through January 7, 2022. The federal comment period for this request was open from March 14, 2022, through April 13, 2022. A total of 4 comments were received through the federal comment period related to the traditional health care practices request. These comments were submitted by various community and advocacy organizations and one Tribal government. All these commenters supported the approval of the proposal to provide coverage for tribal-based practices. Commenters wrote that this aligns with Tribal priorities and recognizes the state's commitment to addressing American Indian and Alaska Native health disparities. One commenter raised questions about inclusion of a payment methodology for payment of traditional health care practitioners and how services will be offered and utilized by Oregon Health Plan members within Tribal communities. Additional information on the payment methodology and how traditional health care practices will be offered and utilized can be found in the STCs.

CMS also consulted with Tribal governments consistent with Executive Order 13175 and the CMS Tribal Consultation Policy by seeking advice and input from Tribal leaders on CMS policies that have Tribal implications. CMS obtained advice and input from the CMS Tribal Technical Advisory Group on July 26, 2023, and March 6, 2024. In addition, CMS held an All Tribes Consultation Webinar on April 3, 2024, and presented on this request during the Department of Health and Human Services Annual Budget Tribal Consultation Session on April 10, 2024. CMS requested Tribal comments from March 6, 2024, through May 3, 2024. A total of 26 comments were received through these consultation efforts that related to the traditional health care practices request.

Comments received through these consultations with Tribes were supportive of Medicaid coverage of traditional health care practices. However, some commenters advised CMS to be flexible in developing its approach to reviewing these demonstration proposals. The most prevalent themes in the comments supporting the demonstration amendments were that CMS needs to be flexible to honor Tribal sovereignty and that urban Indian organization facilities need to be included as they are a vital piece of the Indian health system and are sometimes the only facility accessible to American Indians or Alaska Natives. CMS has made efforts to be inclusive

and flexible in its approach to approving traditional health care practices demonstrations and states may choose to include urban Indian organizations in these demonstrations.

During Tribal consultation, most commenters urged CMS to continue consulting with Tribes and conferring with urban Indian organizations on the design and implementation of demonstrations that would provide coverage of traditional health care practices. Commenters expressed concerns about CMS limiting coverage to only those services delivered by or through IHS or Tribal facilities because it would exclude services provided by urban Indian organization facilities. Commenters relayed during Tribal consultation that Tribal sovereignty requires CMS to let Tribal Nations decide what should be considered an appropriate traditional health care practice provided to their Tribal community. Commenters also wanted to clarify that traditional health care practices should include services provided outside of the four walls of a clinic. After receiving this feedback during the consultation process, CMS decided that urban Indian organizations could be a qualifying provider type option for states. Medicaid coverage and payment for clinic services furnished outside the four walls of a clinic is the topic of a separate CMS rulemaking and we will address comments on that topic as part of that rulemaking.[19] The services that can be covered under this approval are not "clinic services" within the meaning of section 1905(a)(9) of the Act, 42 CFR 440.90, or the pending separate CMS rulemaking; there is no requirement under this demonstration approval that, to be covered, traditional health care practices must be provided in the four walls of a qualifying facility. CMS will also permit IHS, Tribal, and urban Indian organization facilities to determine the scope of services that they provide under this amendment, based on facilities' knowledge of these services and their patient populations.

During Tribal consultation, commenters agreed that using general standards to determine who is a qualified practitioner, including using a high-level position description, is important so that each facility can tailor provider qualifications for their traditional health care practitioners. Commenters expressed interest in how the traditional health care practices approved in demonstrations would align or deviate from the IHCIA and what is currently delivered by or through IHS, Tribal, or urban Indian organization facilities. CMS has developed an approach to approving traditional health care practices demonstration proposals that is intended to be as flexible as possible to allow qualifying facilities to determine practitioner qualifications and scope of practices. Consistent with the IHCIA, IHS, Tribal, and urban Indian organization facilities currently furnish traditional health care practices consistent with the IHS "standards for the provision of health care, health promotion, and disease prevention."[20]

Commenters were highly supportive of providing implementation funding for evaluation activities. However, commenters recommend having Tribes and their practitioners direct demonstration evaluation activities so that they align with the cultural protocols for sharing information for each Tribe, in addition to providing flexibility to design the performance evaluations and customer service satisfaction surveys that are culturally appropriate. With this

---

[19] https://www.federalregister.gov/documents/2024/07/22/2024-15087/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical

[20] 25 U.S.C. 1680u, at https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.

approval, states are encouraged to consult with Tribes and qualifying facilities on the development of evaluation activities.

Consistent with the government-to-government relationship, CMS is available to continue its dialogue with Tribal governments, urban Indian organizations, and the CMS Tribal Technical Advisory Group and to provide technical assistance, as needed.

Other Information

CMS's approval of this amendment is conditioned upon compliance with the enclosed amended set of expenditure authorities and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Felicia Pailen. She is available to answer any questions concerning this amendment. Ms. Pailen's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Felicia.Pailen@cms.hhs.gov

We appreciate your state's commitment to improving the health of people in Oregon, and we look forward to partnering with you on the OHP section 1115(a) demonstration. If you have questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

Enclosures

cc: Nikki Lemon, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

Waiver Authority

NUMBERS: **11-W-00415/10 and 21-W-00073/10**

TITLE: **Oregon Health Plan (OHP)**

AWARDEE: **Oregon Health Authority**

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers shall enable Oregon to implement the Oregon Health Plan (OHP) Demonstration beginning on October 1, 2022 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented in accordance with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

All requirements of the Medicaid program and the Children's Health Insurance Program (CHIP) expressed in law, regulation, and policy statement, not expressly waived or made not applicable in this list or identified as not applicable in the accompanying expenditure authority and/or the approved STCs, shall apply to the demonstration from the approval date, through September 30, 2027, unless otherwise specified.

Title XIX and XXI Waiver Authority/Not Applicable

Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR 431.50

To enable the state to provide benefits through contracts with managed care plans that operate only in certain geographical areas of the state. (Applies to all Medicaid state plan and CHIP populations listed in Attachment C.)

To enable the state to cover Health-Related Social Needs (HRSN) services on a geographically limited, county-by-county basis during the phase in process through December 31, 2024.

Amount, Duration, and Scope of Services **Section 1902(a)(10)(A)**
1902(a)(10)(B)
1902(a)(17)
42 CFR 440.230-250

To enable the state to offer different benefits for individuals whose eligibility is determined based on modified adjusted gross income (MAGI) (other than children under age 21, Youth with Special Health Care Needs, pregnant individuals, and individuals enrolled in the Alternative Benefits Plan) which are consistent with a Prioritized List of Health Services, as defined in STC 4.2.d, subject to certain exceptions for protected benefits. This authority will expire January 1, 2027.

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B) 1902(a)(17)**

To the extent necessary to allow the state to offer the HRSN services as described in STC 9.

To the extent necessary to enable the state to provide HRSN services based on service delivery systems that are not otherwise available to all beneficiaries in the same eligibility group during the phase in process through December 31, 2024.

To the extent necessary to allow the state to offer different benefits for individuals who are eligible under the Expanded Adult Program for Individuals Exempt from Managed Care expenditure authority.

Freedom of Choice **Section 1902(a)(23)(A) 42 CFR 431.51**

To enable the state to restrict freedom-of-choice of provider by offering benefits only through managed care plans (and other insurers) in a manner not authorized by section 1932 of the Act because beneficiaries may not have a choice of managed care plans. This does not authorize restricting freedom of choice of family planning providers. (Applies to all Medicaid state plan and CHIP populations listed in Attachment C.)

Managed Care Plan Enrollment **Section 1902(a)(4) as implemented in 42 CFR 438.56(c) and 438.52**

To enable managed care entities to permit enrollees eligible through Medicaid or the CHIP state plan, a period of only 30 days after enrollment to disenroll without cause, instead of 90 days, except beneficiaries newly entering a managed delivery system. All beneficiaries newly entering a managed delivery system receive 90 days to disenroll. Medicaid and CHIP beneficiaries newly entering a managed delivery system are individuals who have never had Coordinated Care Organization-enrollable Oregon Health Plan eligibility. (Applies to all Medicaid state plan and CHIP populations listed in Attachment C.)

Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

Title XXI Waiver Authority

All requirements of the CHIP program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities and/or these STCs, shall apply to the demonstration project through September 30, 2027. In addition, these waivers may only be implemented consistent with the approved STCs. Waivers associated with the Oregon Health Plan are approved through September 30, 2027.

Under the authority of section 1115(a)(1) of the Act, the following waiver of state plan requirements contained in section 2102 of the Act are granted for the OHP section 1115 demonstration, subject to these STCs.

Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release Section 2102(d)(2)

To enable the state not to provide coverage of the screening, diagnostic, referral, and case management services identified in section 2102(d)(2) of the Act for a targeted low-income child as a state plan benefit in the 30 days prior to the release of such targeted low-income child from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBERS: **11-W-00415/10 and 21-W-00073/10**

TITLE: **Oregon Health Plan (OHP)**

AWARDEE: **Oregon Health Authority**

Under the authority of section 1115(a)(2) the Act, expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed care plans that do not comply with section 1903(m)(2)(a)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in a Coordinated Care Organization (CCO).

2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment**.**

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner**.**

4. Expenditures for primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority that were restricted or eliminated from coverage effective January 1, 2010 for non-pregnant adults enrolled in OHP**.**

5. **Designated State Health Programs (DSHP).** Expenditures for designated programs, described in these STCs, which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. These expenditures are specifically contingent on compliance with STC 13, as well as all other applicable STCs.

6. **Health-Related Social Needs (HRSN) Services.** Expenditures for approved evidence-based health-related social needs services not otherwise eligible for Medicaid payment furnished to individuals who meet the qualifying criteria as described in STC 9. These expenditures are contingent on compliance with STC 13, as well as all other applicable STCs.

7. **Health-Related Social Needs Services Infrastructure.** Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized as part of the approved HRSN infrastructure activities in STC 9. These expenditures are contingent on compliance with STC 13, as well as all other applicable STCs.

8. **Continuous Eligibility.** Expenditures for continued benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.5.c.

9. **Youth with Special Health Care Needs (YSHCN).** Expenditures for services for individuals ages 19 through 26, with income up to 300 percent FPL, and with special health care needs as defined in STC 4.6.

10. **MAGI Expanded Adult Program.**
Expenditures for Medicaid beneficiaries who are age 19 through 64, with household income from 133 up to and including 200 percent of the FPL at the time of their redetermination following the end of continuous enrollment and any subsequent redetermination, and who would otherwise lose eligibility for Medicaid due to income. The expenditure authority is effective until the state has established its Basic Health Program or other state coverage option is available. Authority for these expenditures is effective on the date of the approval letter for the MAGI Expanded Adult Program amendment to this demonstration. New applicants in this income range are not eligible for this expenditure authority.

11. **Expanded Adult Program for Individuals Exempt from Managed Care**
Expenditures for individuals who are age 19 through 64, with household income from 133 up to and including 200 percent of the FPL, who meet the criteria to be exempt from mandatory managed care enrollment in section 1932(a)(2)(C) of the Act, and who are not eligible for Medicare or any other minimum essential coverage (as that term is defined in the Affordable Care Act (ACA)).

12. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

13. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 10.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

14. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

15. **Traditional Health Care Practices Implementation Expenditures.** Expenditures for allowable administrative and implementation costs not otherwise determined eligible for Medicaid payment, to the extent such activities are authorized as described in STC 11.7. This expenditure authority is contingent on compliance with STC 11, as well as all other applicable STCs.

Title XXI Expenditure Authority

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, October 1, 2022 through September 30, 2027, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for demonstration population 4 as described in Attachment C, except those specified in STC 4.5 as not applicable to these expenditure authorities.

16. **Continuous Eligibility.** Expenditures for continued benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.5.c.

17. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Children's Health Insurance Program (CHIP) individuals who are or would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative.

18. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Children's Health Insurance Program beneficiaries who are able to receive services delivered by or through these facilities.

Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services and Traditional Health Care Practices:

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

Comparability; Freedom of Choice **Section 1902(a)(23)**
Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 14 only if the covered traditional health care practices are received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBERS: **11-W-00415/10 and 21-W-00073/10**

TITLE: **Oregon Health Plan (OHP)**

AWARDEE: **Oregon Health Authority**

1. PREFACE

The following are the special terms and conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program section 1115(a) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to these STCs are the Oregon Health Authority (state) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The STCs are effective as of October 1, 2022 through September 30, 2027, unless otherwise specified.

The STCs have been arranged into the following areas:

1. Preface
2. Program Description, Objectives, Historical Context
3. General Program Requirements
4. Eligibility and Enrollment
5. Delivery System
6. Capitation Rates and Performance Measures
7. Measurement of Quality of Care and Access to Care Improvement
8. Designated State Health Programs
9. Health-Related Social Needs
10. Reentry Demonstration Initiative
11. Traditional Health Care Practices
12. Provider Payment Rate Increase Requirement
13. General Reporting Requirements
14. General Financial Requirements
15. Monitoring Budget Neutrality for the Demonstration
16. Monitoring Allotment Neutrality
17. Evaluation of the Demonstration
18. Schedule of the State Deliverables for the Demonstration Period

Additional attachments and appendices have been included to provide supplementary information and guidance for specific STCs.

Attachment A. Developing the Evaluation Design
Attachment B. Preparing the Interim and Summative Evaluation Reports
Attachment C. Summary Chart of Demonstration Populations
Attachment D. Model Tribal Engagement and Collaboration Protocol (reserved)
Attachment E. Coordinated Care Organizations Services Inventory (reserved)
Attachment F. Approved DSHP List
Attachment G. DSHP Claiming Protocol (reserved)
Attachment H. DSHP Sustainability Plan (reserved)
Attachment J. Protocols for HRSN Infrastructure and HRSN Services (reserved)
Attachment K. Oregon Provider Payment Rate Increase Assessment – Attestation Table (reserved)
Attachment L. New Initiatives Implementation Plan (reserved)
Attachment M. Monitoring Protocol (reserved)
Attachment N. Prioritized List Phase-Out Plan (reserved)
Attachment O. Evaluation Design (reserved)
Attachment P. Reentry Demonstration Initiative Implementation Plan (reserved)
Attachment Q. Reentry Demonstration Initiative Reinvestment Plan (reserved)
Appendix. Description of State Operations

2. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases in February 1994. Phase I of the Medicaid demonstration Project started on February 1, 1994. Originally, the demonstration affected Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II added the aged, blind, disabled, and children in state custody/foster care.

Objectives

Under the demonstration, Oregon strives to promote the objectives of title XIX by:

- Providing a basic benefit package;
- Ensuring broad participation by health care providers;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Structuring benefits (what is covered) using a Prioritized List of Health Services;
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing the per capita costs of care for populations through such improvements.
- Expanding the scope of services available through IHS and tribal health facilities, stabilizing the IHS and tribal health system and improving health outcomes for Medicaid and low-income populations utilizing these facilities.

Historical Context: Demonstration Extensions and Amendments

CMS initially approved the Oregon Health Plan (OHP) section 1115 demonstration for a five-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs by using managed care and a Prioritized List of Health Services. This list is updated every two (2) years, whereby services are added, deleted, or moved to a different ranking within the list. CMS approved Oregon's 2002 application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provided premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

In 2007, CMS revised the structure of the populations within the demonstration to reflect updated law and CMS policy. In 2009, CMS approved an amendment to the demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children from birth through age 18 in the state with family incomes from 0 up to and including 300 percent of FPL. In addition, the CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a "reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

In 2012, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and authorized expenditures on certain Designated State Health Programs (DSHP). In October 2013, CMS approved an amendment to add tribal health programs supplemental primary care payments to the demonstration. The amendment allows the state to make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority.

In December 2013, CMS approved amendments to align eligibility, populations, and benefits in the demonstration with provisions in the Affordable Care Act and approved a one-year extension of uncompensated care payments to IHS or tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority.

In January 2017, CMS approved an extension to continue and enhance Oregon's Health System Transformation. The extension of OHP sought to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon utilized community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement to improve the coordinated care model.

In February 2022, the state submitted an application to extend the demonstration, continuing foundational elements of OHP, while incorporating significant changes to focus on addressing health inequities within the state. Oregon's requests aim to make meaningful improvements to health outcomes across the state by improving access, addressing health equity, strengthening health care systems, and addressing Health-Related Social Needs (HRSN) that contribute to poor health outcomes of Medicaid beneficiaries within the state. Approval of this request will allow the state to: provide continuous eligibility for children from birth through age five, as well as twenty-four month continuous eligibility for those ages six and above; expand coverage to Youth with Special Health Care Needs ages nineteen through twenty-six; cover new services to address a defined set of evidence-based health-related social needs; and authorize DSHP funding to support state funding of these initiatives.

In April 2023, CMS approved an amendment to this demonstration which continues enrollment for those beneficiaries with incomes from 133 up to and including 200 percent of the federal poverty level (FPL) at the time of their redetermination following the end of the continuous enrollment condition under section 6008(b)(3) of the Families First Coronavirus Response Act (as amended) and any subsequent redetermination, and who would otherwise lose eligibility for Medicaid due to income. Applicants ages 19 through 64 who apply for Medicaid on or after the date of the approval letter who have household incomes from 133 up to and including 200 percent of the FPL at the time they submit their Medicaid applications are not eligible for the MAGI expanded Adult Program. The objective is to reduce the loss of health care coverage as a result of the end of the continuous enrollment condition of the Families First Coronavirus Response Act (FFCRA).

In June 2024, CMS approved an amendment to add coverage for individuals ages 19 through 64 with household incomes from 133 up to and including 200 percent of the federal poverty level (FPL), who meet the criteria to be exempt from mandatory managed care enrollment in section 1932(a)(2)(C) of the Act and who are not eligible for Medicare or any other minimum essential coverage (as that term is defined in the Affordable Care Act (ACA)). Section 1932(a)(2)(C) exempts any individual who is an Indian as defined by the Indian Health Care Improvement Act of 1976.[1] The amendment will allow individuals who would otherwise be eligible for coverage under the state's Basic Health Program (BHP)[2] to receive a Medicaid benefits package that generally aligns with the coverage available through the BHP, without requiring enrollment in managed care, as would otherwise be required for enrollment under the state's BHP. Individuals who are eligible for Medicare and other minimum essential coverage (as that term is defined in the ACA) are excluded from participation in the state's BHP, and eligibility for the group added through this demonstration amendment generally aligns with the eligibility criteria for the BHP.

On October 16, 2024, CMS approved an amendment to provide expenditure authority for coverage of traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and

[1] CMS has defined "Indian" as used in section 1932(a)(2)(C) of the Act in 42 CFR 438.14(a), to mean any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.

[2] Eligibility under this Medicaid demonstration excludes them from BHP eligibility.

Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid and CHIP beneficiaries who are able to receive services delivered by or through these facilities.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state thirty (30) business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or the day such legislation was required to be in effect under federal law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to demonstration eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health and Human Services (HHS) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than one hundred twenty (120) calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny (or delay approval of) a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed amendment, which isolates (by eligibility group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. Updates provided by the state to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring, and measurement of the provisions.

3.8. **Extension of the Demonstration.** If the state intends to request an extension of the demonstration, it must apply to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 CFR 431.412(c). If the state does not intend to request an extension of a demonstration beyond the period authorized in these STCs, it must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration, in whole or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures.** The state must comply with all applicable notice requirements found in 42 CFR part 431 subpart E, including sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as

required in 42 CFR 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. **Exemption from Partial Notice Procedures 42 CFR 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **Federal Financial Participation.** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with termination of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Expiring Demonstration Authority.** With the exception of changes to EPSDT and the Prioritized List of Health Services outlined in STC 4.2.c and 13.8, for demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination as discussed in the October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR

435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.

d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to applying to extend the demonstration. For applications to amend the demonstration, the state must comply with state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid state plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

a. **Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations.** In states with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 State Medicaid Director letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR 431.408(b)(2)).

b. **Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments.** In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

c. **Public Notice.** The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

3.14. The 1115 demonstration will have no impact on American Indian and Alaska Natives (AI/AN) rights to exemption from enrollment in managed care organizations, or the requirements for CCOs and other managed care plans to come into compliance with the CMS 2390-F, regulations regarding Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability published April 26, 2016, including the AI/AN specific provisions at 42 CFR 438.14.

3.15. **Indian Health Care Providers.** Pursuant to 25 U.S.C. 1647a(a)(1), the state will accept an entity that is operated by Indian Health Service (IHS), an Indian tribe, tribal organization, or urban Indian health (collectively referred to as Indian Health Care Providers or "IHCP") program as a provider eligible to be enrolled with Oregon Medicaid and receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity attests that it meets generally applicable state or other requirements for participation as a provider of health care services under the program.

3.16. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.17. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the single state Medicaid agency must maintain authority, accountability, and oversight of the program. The state Medicaid agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and any other contracted entities. The single state Medicaid agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.18. **Common Rule Exemption.** The state must ensure the only involvement of human subjects in research activities authorized and/or required by this demonstration is for projects conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration, as represented in these approved STCs, meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligibility.** This demonstration affects all mandatory Medicaid and CHIP eligibility groups set forth in Oregon's state plan and optional groups set forth in the state plan, except as otherwise noted in the waivers and expenditure authorities for this demonstration and in these STCs. Any Medicaid and/or CHIP state plan amendments to the eligibility groups apply to this demonstration.

4.2. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Oregon Health Authority (OHA). All individuals eligible under the Medicaid state plan, including those eligible through mandatory and optional groups, or 1115 expenditure authority, will receive either the OHP Plus benefit plan or the Alternative Benefits Plan approved in the Medicaid state plan.

a. **OHP Populations.** The state will provide health care coverage through the OHP programs defined within these special terms and conditions (STCs) to the Medicaid mandatory and optional groups under the Oregon state plans, as defined in Attachment C.

b. **Applicability of Medicaid Laws and Regulations.** All requirements expressed in Medicaid laws, regulations and policies apply to all the populations affected by this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration.

c. **Summary of OHP Benefit Structure.** The Oregon Health Plan demonstration has two components, offered directly through OHP Plus and the Alternative Benefit Plan. Most beneficiaries under either program receive services through managed/coordinated care delivery systems.

All beneficiaries receive the OHP Plus benefit (populations 1, 3, 4, 5, 6, 7, 8, 9, 10, 21, 23, 24 and 25 in Attachment C), which consists of:

i. All benefits covered under the approved state plan that are also consistent with the Prioritized List of Health Services to the extent that the state has authority under its section 1115 demonstration to apply the Prioritized List to coverage, through its waiver phase-out date (described in STC 4.2.d);

ii. Prior to January 1, 2023, for children at or over 1 year and younger than 21 years old, and YSHCN, section 1905(a) services that are determined necessary to correct or ameliorate physical and mental illnesses and conditions, in accordance with the EPSDT definition at section 1905(r) of the Act, that are consistent with the Prioritized List;

iii. Prior to January 1, 2023, for children under 1 year of age, section 1905(a) services that are determined necessary to correct or ameliorate physical and mental illnesses and conditions, in accordance with the EPSDT definition at section 1905(r) of the Act, regardless of their consistency with the state plan or the Prioritized List;

iv. Beginning January 1, 2023, for all children younger than 21 years old, and YSHCN, all section 1905(a) services that are determined necessary to correct or ameliorate physical and mental illnesses and conditions, regardless of whether they are included in the state plan, in accordance with the EPSDT definition at section 1905(r) of the Act;

v. Prior to January 1, 2027, for pregnant individuals, the entire Medicaid state plan Services Benefit Package, subject to necessary pre-authorization for services not consistent with the Prioritized List, through its waiver phase-out date;

vi. Services of traditional health workers (described in STC 4.2.e);

vii. Primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority, that were restricted or eliminated from coverage subject to the Prioritized List effective January 1, 2010 for non-pregnant adults enrolled in OHP;

viii. Services of patient-centered primary care homes (described in STC 4.2.f); and

ix. The following Medicaid benefits to the extent otherwise provided under the state plan. These services are not included in the benefit package for populations 24 and 25.

    i. Long Term Care Services;

        a. Nursing Facility Services

        b. Home- and Community-Based Services

        c. Community Supported Living Services

d. Programs of All-Inclusive Care Elderly

ii. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services; and

iii. Medicare Premium Payments and Medicare cost sharing.

d. **Prioritized List of Health Services.** One of the distinguishing features of the OHP demonstration is that OHP Plus benefits are based on the Prioritized List of Health Services ("the Prioritized List", or, "the List"), which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services. The waiver of amount, duration, and scope as related to the Prioritized List will end by January 1, 2027. As of that date, the Oregon Health Plan must comply with all state plan rules, except as otherwise provided under this demonstration.

i. **Oversight -- The Health Evidence Review Commission (HERC).** The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Health Policy & Analytics Division. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.

ii. **Modifications to the Prioritized List.** Until January 1, 2027, modifications to the Prioritized List require federal approval through submission of an amendment, as described in STC 3.7, in order to ensure the Prioritized List is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the Prioritized List of Health Services is maintained by the state of Oregon at https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx. During the demonstration period and as specified below, the state will not reduce benefits.

iii. **Ordering of the Prioritized List.** The Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g., common colds); (b) are primarily cosmetic in nature (e.g., benign skin lesions); or (c) have no effective treatments available (e.g., metastatic cancers).

iv. **Updating the Prioritized List.** The Commission is charged with updating the list for every regular legislative session occurring in odd-numbered years. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.

v. **Non-covered Condition and Treatment Pairs.** In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The state must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the Prioritized List of Health Services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The state shall provide, through a telephone information line and through the applicable appeals process under 42 CFR part 431 subpart E, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

vi. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

i. The state will maintain the cutoff point for coverage at the same position on the Prioritized List relative to the 2022-2023 List for the remainder of the demonstration as noted above in STC 4.2.d.ii. For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request in compliance with STC 3.7 will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in STC 15.

ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.

iii. For a change to the list not defined above that meets the terms of STCs 3.6 and 3.7, an amendment request will be submitted to CMS.

e. **Traditional Health Workers (THW).** THWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. THWs may serve individuals regardless of the delivery system in which they are enrolled.

f. **Patient Centered Primary Care Homes (PCPCH).** The state includes PCPCH services in the OHP Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement.

4.3. **Alternative Benefit Plan.** The mandatory state plan group, new adult group (Population 23 in Attachment C), will receive a benefits package provided through the state's approved alternative benefit plan (ABP) in the Medicaid state plan. Under the authority for Secretary-approved coverage as an ABP, CMS is approving a package of benefits that the state has determined includes at least all essential health benefits as defined using the required process, and other benefits that are both: 1) covered in accordance with the traditional benefit package under the approved state plan and 2) consistent with the state's Prioritized List, as approved by the Secretary, to the extent that the state has authority under its section 1115 demonstration to apply the Prioritized List to coverage.

4.4. **Breast and Cervical Cancer Treatment Program (BCCTP).** Individuals determined to be eligible as specified in the state plan for BCCTP services (population 21 in Attachment C) will be enrolled in the Oregon Health Plan.

4.5. **Continuous Eligibility.**

a. **Affected Individuals.**

i. Except as provided in STC 4.5.c, individuals ages zero through five, excluding individuals eligible for Medicaid on the basis of 42 CFR 435.217, who enroll in Medicaid or CHIP shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls; and

ii. Except as provided in STC 4.5.c, individuals ages six and older, excluding individuals eligible for Medicaid on the basis of 42 CFR 435.217, who enroll in Medicaid or CHIP shall qualify for a 24-month continuous eligibility period.

b. **Continuous Eligibility Period.** The state is authorized to provide continuous eligibility for the populations and associated durations specified in Table 1, regardless

of the delivery system through which these populations receive Medicaid or CHIP benefits. This provision shall be effective for beneficiaries through age 18 beginning with enrollments and renewals that are undertaken on or after the date when the continuous coverage requirement authorized by the Families First Coronavirus Response Act (FFCRA) ends. Subject to the effective date, once effective, coverage shall be continuous as specified below. For adult populations, this provision shall be effective beginning July 1, 2023 or after the date when the continuous coverage requirement authorized by the FFCRA ends, whichever is later.

i. For children ages 0 through 5 who qualify for continuous eligibility until the end of the month in which their 6th birthday falls, the child's continuous eligibility period begins on the effective date of the child's eligibility under 42 CFR 435.915 or 457.340(g). The state will redetermine eligibility consistent with 42 CFR 435.916 or 457.343 when the child turns age 6, and if eligible, provide a 24-month continuous eligibility period consistent with the requirements in this demonstration for individuals ages 6 and older. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 4.5.c.

ii. For individuals that qualify for 24 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915 or 457.340(g), or the effective date of the most recent renewal of eligibility. Given individuals are continuously eligible regardless of changes in circumstances (except as provided under STC 4.5.c), the state will conduct renewals of eligibility consistent with 42 CFR 435.916 or 457.343, as applicable, for individuals who qualify for 24 months of continuous eligibility at the end of the individual's continuous eligibility period. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 4.5.c.

Table 1. Eligible Populations and Associated Duration for Continuous Eligibility

Population	Duration of Continuous Eligibility
Children ages 0 through 5, excluding individuals eligible for Medicaid on the basis on 42 CFR 435.217	Until the end of the month in which their 6th birthday falls
Individuals ages 6 and above, excluding individuals eligible for Medicaid on the basis on 42 CFR 435.217	24 months

Individuals who are eligible for Medicaid on the basis of 42 CFR 435.217 are not eligible for continuous eligibility. Continuous eligibility applies to Medicaid and CHIP enrollees in all other Oregon Health Plan eligibility categories, except as specified in STC 4.5.c.

c. **Exceptions.** Notwithstanding STC 4.5.b, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid or CHIP eligibility shall be redetermined or terminated:

i. The individual is no longer an Oregon resident;

ii. The individual requests termination of eligibility;

iii. The individual is enrolled in the Expanded Adult Program for Individuals Exempt from Managed Care specified in Expenditure Authority 11 and becomes enrolled in Medicare or other minimum essential coverage (as that term is defined in the ACA) (eligibility for Medicare or other minimum essential coverage, regardless of whether an individual has enrolled in that other minimum essential coverage, will lead to a determination of ineligibility for this demonstration group when eligibility is redetermined at the end of the continuous eligibility period);

iv. The individual dies; or

v. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

d. **Beneficiary-Reported Information and Periodic Data Checks.** The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d) or 457.380. The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) or 457.343 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j) or 457.380.

As part of a deliverable titled New Initiatives Implementation Plan (see STC 13.4), the state must submit a description of the processes to perform the verifications described above. Furthermore, the state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 13.6).

e. **Annual Updates to Beneficiary Information.** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information, and must attempt to update beneficiary contact information on an annual basis, which may include annually checking data sources and partnering with coordinated care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d) or 457.380(f), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

In the New Initiatives Implementation Plan (see STC 13.4), the state must submit a description of the processes to update beneficiary contact information on an annual basis. Each demonstration year, through the Annual Monitoring Reports (see STC 13.6), the state must submit to CMS a summary of activities and outcomes from these efforts.

4.6. **Youth with Special Health Care Needs (YSHCN).**

a. **Eligibility for YSHCN Benefits.** Beginning no earlier than July 1, 2023, individuals will be eligible for YSHCN benefits if they are between ages 19 and 26, have income up to 300 percent FPL, and meet at least one of the criteria below. Individuals must also have met the eligibility criteria prior to turning age 19. Individuals eligible for YSHCN benefits are eligible for 24 months of continuous eligibility as described in STC 4.5.a.ii.

i. Have one or more serious chronic conditions as represented by the Pediatric Medical Complexity Algorithm (PCMA)'s list of complex chronic conditions;

ii. Have a serious emotional disturbance or serious mental health issue;

iii. Have a diagnosed intellectual or developmental disability in accordance with Oregon Administrative Rules governed by Oregon's Office of Developmental Disabilities Services;

iv. Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or

v. Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions as described in the New Initiatives Implementation Plan (see STC 13.4).

b. **YSHCN Enrollment.** The effective date of enrollment is established by the state based on the determination that the individual is eligible and may begin receiving

YSHCN services. An individual may enroll through one of the pathways below, if they meet the age requirement and are either:

i. Eligible for an established Medicaid state plan eligibility group (in which case income is deemed to meet the financial criteria for the purpose of YSHCN) and meet the non-financial eligibility requirement for YSHCN; or

ii. Not eligible for an established Medicaid state plan eligibility group upon reaching age 19, but meet the financial and non-financial eligibility criteria for YSHCN.

c. **YSHCN Benefits.** Individuals enrolled as YSHCN will receive YSHCN benefits as described in STC 4.2.c and HSRN services as described in STC 9. The state will ensure that individuals enrolled as YSHCN will be screened for specific HRSN and may qualify for related services for up to 12 months, unless otherwise specified in STC 9. The state will also ensure that individuals enrolled as YSHCN are reassessed for their HRSN at least annually.

5. DELIVERY SYSTEM

Health System

5.1. Health care services authorized under this demonstration may be provided through (1) fee-for-service (FFS) for beneficiaries who are not required to enroll into a CCO, except as outlined in STC 5.1.a, or (2) managed care organizations called Coordinated Care Organizations (CCOs). Individuals who are not required to enroll into a CCO or who may disenroll from a CCO in accordance with 42 CFR 438.52 or who do not have another CCO option in their geographic area, will receive their services through a FFS delivery system except as outlined in STC 5.1.a, as applicable.

a. Individuals receiving covered health care services through the FFS delivery system may be required to receive dental services through a managed care delivery system.

b. Patient Centered Primary Care Homes (PCPCH): the PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP beneficiaries whether they are enrolled with a CCO or served through the FFS delivery system.

5.2. The majority of health care services are provided through a managed care delivery system, CCOs. The CCOs provide medical, behavioral health services and dental services. The state contracts with CCOs.

a. Enrollment of OHP Populations into CCOs

i. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.

    i. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.

ii. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled).

iii. Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment.

iv. Dually eligible individuals will be voluntarily enrolled in a CCO via passive enrollment pursuant to 42 CFR 438.54(c) with the option to opt out and return to FFS at any time.

    i. Dually eligible individuals will receive a ninety (90) day notice regarding passive enrollment in a CCO, where sufficient capacity exists.

    ii. Dually eligible individuals who live in an area with two CCOs will be enrolled using the same process as other OHP members, which is based on previous enrollment, enrollment of other family members, and CCO area capacity limit.

    iii. Dually eligible individuals who are enrolled in a dual eligible special needs plan (D-SNP) will be assigned to the affiliated CCO. Additionally, dually eligible individuals who are enrolled in a Medicare Advantage plan will be assigned to the affiliated CCO.

v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

vi. OHA member transition strategies for FFS members with special considerations include:

    i. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:

        a. Care management requirements based on the beneficiary's medical condition;

b. Considerations of continuity of treatment, services, and providers, including behavioral health referrals and living situations;

c. Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services);

d. Availability of medically appropriate medications under the CCO formulary; and

e. Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team.

ii. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

iii. For dually eligible individuals, CCOs will be required to provide a minimum 90-day continuity of care period.

Description of Delivery System

5.3. **Definition and Role of Coordinated Care Organizations.** CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR part 438 unless a requirement has been specifically identified in the waiver authorities as expressly waived or specified as not applicable to an expenditure authority for this demonstration. CCOs will provide a governance structure to align the specialized services under one managed care organization. CCOs will partner with OHA to further the state's implementation of PCPCH and utilization of Traditional Health Workers (THWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

a. **CCO Governance and Organizational Relationships.**

i. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see STC 5.3.a.ii); and at least two members from the community at large to ensure that the organization's decision making is consistent with the community members' values.

ii. Community Advisory Council (CAC). The CCOs are required to convene a CAC that includes representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be an ongoing council and meet no less frequently than once every three

months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.

iii. Clinical Advisory Panel. The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.

iv. Partnerships. The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.

v. Community Health Needs Assessment. Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The state encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

5.4. **Alternate Delivery System.** The FFS delivery system applicable to some demonstration populations will continue as described in STC 4.

5.5. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.

5.6. **Compliance with Managed Care Requirements.** The state must meet the requirements of 42 CFR part 438 unless a requirement of part 438 has been identified in the waiver authorities as expressly waived or specified as not applicable to an expenditure authority for this demonstration.

5.7. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**

a. **Mandatory Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive benefits pursuant to STCs 4 and 5. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR part 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to twelve (12) months. Table 2 below illustrates the mandatory and affirmative choice (i.e., “opt-in”) populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given[3]
1, 3, 4, 5, 6, 7, 8, and 10	Individuals of the identified populations other than those footnoted.[4]	Mandatory in	Other CCO if available; FFS with cause
21	Breast and Cervical Cancer Treatment Program	Mandatory in	Other CCO if available; FFS with cause
23	New eligible adults	Mandatory in	Other CCO, if available; FFS with cause
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
1-11, 21	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid state plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid state plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid state plan	Individuals who are Transplant Rx only	Out	N/A
24	MAGI Expanded Adult Program	Mandatory in	Other CCO, if available; FFS with cause
25	Expanded Adult Program for	Opt-in	N/A

[3] See (b) below for more information on disenrollment/plan change options and timelines.

[4] Exceptions include individuals who are American Indian or Alaska Native who are permitted to enroll, but not mandatorily enrolled. Individuals who are dually eligible for Medicare and Medicaid will be passively enrolled with the option to opt out and return to fee-for-service at any time.

Population	Description	In/Out of CCOs	Disenrollment Options Given[3]
	Individuals Exempt from Managed Care		

b. **Disenrollment.** The information in Table 3 is applicable to all managed care enrollees.

Table 3. Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR part 438.
Eligibility Redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

5.8. **Network Adequacy and Access Requirements.** The state must ensure that any CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the state's quality strategy required by 42 CFR 438.340.

5.9. **Required Notice for Change in CCO Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

5.10. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the state will implement contingency planning in consultation with CMS to assure enrollee continuity of care.

5.11. **Tribal Engagement and Collaboration Protocol.** The state, with tribes, Indian Health Service facilities, and urban Indian Health Programs, must develop and submit to CMS for approval of a Model Tribal Engagement and Collaboration Protocol (Attachment D) no later

than 90 calendar days after the demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment D of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

CCOs will be required to adopt either the state's Model CCO Tribal Engagement and Collaboration Protocol or a policy agreed upon in writing by the CCO and every tribe and Indian Health Care Provider (IHCP) in the CCO's region. The model protocol establishes minimum requirements, such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for IHCPs, and protocols for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and IHCP.

In addition to adopting the Model CCO Tribal Engagement and Collaboration Protocol, CCO governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on tribes in their region and IHCPs and on the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration among (a) tribes, IHS facilities, and urban Indian health programs and (b) CCOs and the state, will be described by the Model CCO Tribal Engagement and Collaboration Protocol (Attachment D).

6. CAPITATION RATES AND PERFORMANCE MEASURES

6.1. **Principles for Payment Methods that Support the Three-Part Aim.** The state will employ the following concepts in its payment methods to CCOs:

a. The state will transition to a payment system that rewards health outcomes improvement and not volume of services. As part of this transition, the state will ensure through its CCO contracts that value-based payment (VBP) arrangements, structured to improve quality and manage cost growth, are used by CCOs with their network providers. The state will continue to develop the CCO VBP Roadmap that describes how the state, CCOs and network providers will achieve a set target of VBP payments by the end of the demonstration period. The CCO VBP Roadmap provides a broad definition of VBP and includes a schedule that ensures phased-in implementation over the course of the demonstration. The state will work with CCOs and network providers to implement this CCO VBP Roadmap. To the extent that the state requires specific payment mechanisms that direct CCOs' expenditures under the contracts between the state and the CCOs, the state shall comply with 42 CFR 438.6(c).

b. The state will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services, other than specific services identified in non-risk payment arrangements with the CCOs.

i. CCOs will be at risk for services included in the CCO Services Inventory, which will be appended as Attachment E. While the intent is to include as many services as possible within the global budget payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding any additional services to the global budget.

6.2. **State Oversight of Medical Loss Ratio (MLR)**

a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.

i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf. The state must submit its plan to operationalize STC 6.2.a through d to CMS for review and approval at DMCPMLR@cms.hhs.gov no later than April 1, 2023. This plan must outline key deliverables and timelines to meet the requirements of STC 6.2.a through d.

b. Effective January 1, 2024, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

c. No later than January 1, 2025, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

d. STC 6.2.a, 6.2.b, and 6.2.c must apply for all of the following entities:

i. Risk-based plans for which the state receives federal financial participation for associated expenditures;

ii. Full and partially delegated plans;

iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 6.2.d.ii; and

iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 6.2.d.iii.

e. The state must work with CMS to effectuate an audit of the MLR data covering all full rating periods of this 1115 demonstration renewal package. The audit must occur no sooner than April 1, 2026, and ideally later in 2027 to allow the state time to review and finalize the calendar year 2026 MLRs.

f. The state will update the CCO contract language to require the CCOs to provide HRSN services as described in STC 9. When HRSN services are included in risk-based capitation rates, as outlined in STC 9.9.d, HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.

    i. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 18 months prior to the implementation of HRSN services in risk-based capitation rates. The state shall submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

g. The state will update the CCO contract language to require the CCOs to consider using alternative services including "in lieu of services" pursuant to 42 CFR 438.3(e)(2), "health-related services" and "community benefit initiatives" described in 42 CFR 438.3(e)(1)(i) and 438.8(f)(3)(v), respectively. CCOs are at liberty to offer services not covered under the state plan, as allowed under 42 CFR 438.3(e)(1)(i). Since enrollees may need or benefit from additional services that are not in lieu of services, but could ultimately improve the enrollee's health, CCOs should consider providing these services as necessary.

    i. For purposes of this STC, an "in lieu of service" is a setting or service that is determined by the state to be a medically appropriate and cost-effective substitute for a service or setting covered under the state plan. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).

    ii. For the purposes of these STCs, "health-related services" are cost-effective services offered as an adjunct to covered benefits.

        i. Health-related services are not considered Medicaid covered services;

        ii. Health-related services are intended to promote the efficient use of resources and, in many cases, target social determinants of health; unlike in lieu of services, health-related services are not substitutes for state plans services; and

        iii. CCO expenditures for health-related services must be paid for from the CCO's savings from improved health and more efficient use of resources, and will not be included in capitation rate setting (except to the extent that such services may result in savings or performance-based incentives as described in STC 6.2.h).

iii. For the purposes of these STCs, "community benefit initiatives" are community level interventions focused on improving population health and are defined in 42 CFR 438.8(f)(3)(v). CCO expenditures for community benefit initiatives must be paid for from the CCO's savings from improved health and more efficient use of resources and should not be included in capitation rate setting.

iv. The CCO contracts must not require CCOs to provide specific in lieu of services, health-related services, or community benefit initiatives, although the contract may require the CCOs to consider the use of such services when it could improve an enrollee's health or promote the efficient use of resources. If the CCO elects to provide health-related services and/or community benefit initiatives, it must report these expenditures to the state using the procedures noted in the contract.

    i. An enrollee cannot be required to use an in lieu of service or a health-related service. A CCO's offer to provide an in lieu of service or health-related service does not change the CCO's obligation to provide all covered services under the contract between the state and the CCO.

    ii. The state must comply with the contracting, reporting and rate-setting requirements for in lieu of services as specified in 42 CFR 438.3(e)(2).

    iii. Using the information provided by the CCOs from a state-developed monitoring and oversight process, separate from the HRSN monitoring and oversight process, the state will report on the health-related services and/or community benefit initiatives provided through the CCO contracts, including the effectiveness of the services in improving health and deterring higher cost care.

    iv. For purposes of Medical Loss Ratio reporting, CCOs must only include those expenditures under the contract between the state and the CCO that meet the inclusion criteria for the Medical Loss Ratio reporting as described in 42 CFR 438.8. To the extent that expenditures for health-related services meet the definition for: (a) activities that improve health care quality, as defined in 45 CFR 158.150; or (b) expenditures related to health information technology and meaningful use requirements, as defined in 45 CFR 158.151, those expenditures shall be included in the numerator of the Medical Loss Ratio as described in 42 CFR 438.8(e)(3). Community benefit initiatives that meet the definition in 45 CFR 158.162(c) may be included in the MLR denominator as an adjustment to premium revenue subject to the limits stated in 42 CFR 438.8(f)(3)(v).

h. The contract between the CCOs and state may include performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. That is, the contract may include incentives to encourage CCOs' creative use of health-related service delivery to improve health outcomes and reduce growth in per capita expenditures.

i. As CCOs provide health-related services that are more cost-effective than state plan services, the per capita growth rate for covered services in capitation rates should decrease relative to what it would have been in absence of health-related services. The state will offset the decrease with changes in the methodology to develop capitation rates; the rates will be developed and documented consistent with requirements in STC 5.6. Specifically, the state will develop capitation rates with an underwriting margin that varies by CCO, as opposed to a fixed percentage of premium for each CCO. The capitation rates for CCOs identified as high performing (i.e., those showing quality improvement and cost reduction in the previous years) will have a higher percentage of underwriting margin built into their capitation rates than lower performing CCOs.

ii. The state will establish an incentive or withhold arrangement or a combination of incentive and withhold arrangements. Whether the financial structure is an incentive, withhold, or combination of the two, the arrangement will be designed to incentivize improvements and therefore referred to as an incentive. Incentives must be designed to reduce costs and improve health care outcomes. When developing the incentive, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing. The incentive will comply with the relevant portions of 42 CFR 438.6(c). The state will alert the CCOs that the incentive will be tied to each CCO's performance on the quality and access metrics established under STC 7, and that the whole incentive amount will be at risk.

iii. Incentives must be correlatively reflected in the CCO/provider agreements to ensure that a portion of the incentives are passed through to providers to reflect the arrangement with the state-CCO contract. The state's contracts with CCOs must require that incentive payment contracts between CCOs and providers have a defined effective period that can be tied to the applicable MLR periods and must be signed and dated by all appropriate parties before the commencement of the applicable effective period. In addition, all incentive payment contracts must include defined metrics that the provider must meet to receive the incentive payment and specify a payment methodology that can be clearly linked to successful completion of such metrics including when the payment will be made. The state's contracts with the CCOs must include language prohibiting the use of attestations as the sole supporting documentation for provider payment data that are included in MLR reporting.

iv. Consistent with Table 4, each subsequent demonstration year's capitation rates and incentives will be set in the demonstration year preceding the implementation in order to apply program experience as the program matures (e.g., DY21 rates and incentives will be set in DY20). The state will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

Table 4. Demonstration Years.

Demonstration Year	Time Period
20	July 1, 2021 – September 30, 2022
21	October 1, 2022 – September 30, 2023
22	October 1, 2023 – September 30, 2024
23	October 1, 2024 – September 30, 2025
24	October 1, 2025 – September 30, 2026
25	October 1, 2026 – September 30, 2027

7. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

7.1. **Overview.** Improving access and quality is a key component of the state health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met.

7.2. **Incentive Metrics Governance.** The state's strategy for robust measurement includes public processes to inform decisions about which measures to incentivize, where to set benchmarks, and how to prioritize needs for new metrics. This public process will include one or more public committees, in accordance with Oregon statutes that address decision-making for the metrics program.

7.3. **Utilization of New Services.** The state and CCOs must track discrete services to identify whether the service is a state plan service or other service paid for with Medicaid funds under the capitation rate or a non-risk basis and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement and as required by 42 CFR 438.242.

7.4. **Quality and Access Data Reporting from the State to CMS.** In accordance with STC 13.6, the state will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the state will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 90 days of the demonstration approval, the state will submit and CMS will approve a reporting format.

7.5. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**

a. **Statewide quality, access, and expenditure monitoring and analysis.** The state shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The state

must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights.

b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within thirty (30) days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to technical assistance, improvement plans, development of guidance, and/or focused learning collaboratives or workgroups to target underlying issues affecting outcomes, performance, access and cost.

c. **Additional actions taken if goals are not achieved.** If the interventions undertaken pursuant to STC 7.5.b do not result in improved performance in identified areas of concern within ninety (90) days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the state placing the CCO on a corrective action plan. The state must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts.

7.6. **External Quality Review Organization.** The state is required to meet all requirements found in 42 CFR 438.364. The state must finalize the annual technical report by April 30th of each year, make available to CMS and post the most recent copy of the annual EQR technical report on the state's website as required under 42 CFR 438.10(c)(2) by April 30th of each year. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

8. DESIGNATED STATE HEALTH PROGRAMS

8.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs (DSHP) subject to the limits described in STC 8. DSHP authority will allow the state to support DSHP-Funded Initiatives, as described in STC 8.3(c). This DSHP authority will be available from DY21-DY25.

a. The DSHP will have an established limit in the amount of $535 million total computable expenditures, in aggregate, for DY21-DY25.

b. The state may claim FFP for up to the annual amounts outlined in Table 5, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to

one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year.

Table 5. Annual Limits in Total Computable Expenditures for DSHP.

	DY21	DY22	DY23	DY24	DY25
Total Computable Expenditures	$51 million	$182 million	$143 million	$159 million	$0 million

c. The state must contribute $71 million in original, non-freed up DSHP funds, for the 5-year demonstration period towards its initiatives described in STC 4.6 and 9. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.

e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the demonstration approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. Only after CMS approves the list and ensures that none of the requested state programs fall within the exclusions listed in STC 8.2 can the state begin claiming FFP for DSHP expenditures. The Approved DSHP List will be appended to the STCs as Attachment F.

8.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, two percent of total provider expenditures or claims through DSHP

identified as described in STC 8.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 8.1.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

   i. Bricks and mortar;

   ii. Shelters, vaccines, and medications for animals;

   iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

   iv. Revolving capital funds; and

   v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

8.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.

b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. Funding for DSHP-funded initiatives will not be supplanting, nor merely supplementing existing services or programs. DSHP-funded initiatives must be new services or programs within the state. Funding for DSHP-funded initiatives specifically associated with infrastructure start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

i. Youth with Special Health Care Needs

ii. HRSN Services

iii. HRSN Infrastructure

iv. Reentry Pre-Release Services and Administrative Costs

8.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS, within 150 calendar days of the approval of the OHP Demonstration, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to receive FFP until the protocol is approved by CMS. Once approved by CMS, the protocol will be appended as Attachment G to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

i. Certification or attestation of expenditures.

ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 8.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

8.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that the DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the general administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with CMS-approved DSHP Claiming Protocol in Attachment G.

8.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than December 31, 2025, after the approval of this authority. Upon CMS approval, the plan will be appended as Attachment H to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

9. HEALTH-RELATED SOCIAL NEEDS

9.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for the specified evidence-based HRSN services identified in STC 9.2, subject to the restrictions described below and in STC 12. Expenditures for HRSN services are limited to costs not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to beneficiaries through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; beneficiaries can opt out of HRSN services at any time; and HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services to CMS as outlined in STC 9.6 and Attachment J.

9.2. **Allowable HRSN services.** The state may cover the following HRSN services:

a. Housing Supports, including:

i. Rent/temporary housing for up to 6 months, specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), residential mental health and substance use disorder facilities, or inpatient psychiatric units, correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care

ii. Utility costs including activation expenses and back payments to secure utilities, limited to individuals receiving rent/temporary housing as described in STC 9.2.a.i

iii. Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention

iv. Housing transition navigation services

v. One-time transition and moving costs (e.g., security deposit, first-month's rent, utilities activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture)

vi. Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification

vii. Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention

viii. Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation

b. Nutrition Supports

i. Nutrition counseling and education, including on healthy meal preparation

ii. Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months

iii. Meals or pantry stocking for children under 21, YSHCN, and pregnant individuals, up to 3 meals a day delivered in the home or private residence, for up to 6 months

iv. Fruit and vegetable prescriptions, for up to 6 months

c. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees

9.3. **HRSN Infrastructure.**

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to STC 13. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tool and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems

ii. Development of business or operational practices – e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation

iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures

iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 6. Annual Limits in Total Computable Expenditures for HRSN Infrastructure

	DY21	DY22	DY23	DY24	DY25
Total Computable Expenditures	$51M	$53M	$5M	$5M	$5M

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure, and Provider Qualifications for HRSN Services is approved, as described in STC 9.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

9.4. **Excluded HRSN services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (bricks and mortar), except as needed for approved medically-necessary home modifications as described in STC 9.2.a.viii;

b. Capital investments;

c. Room and board, except as described in STCs 9.2.a.i and 9.2.b.ii through iv;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting, except those HRSN-related case management services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School-based programs for children that supplant Medicaid state plan programs;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this demonstration.

9.5. **Covered Populations.** Expenditures for HRSN services may only be made for the targeted populations specified below for individuals in all populations listed in Attachment C except for populations 24 and 25. To receive HRSN services, individuals in the targeted populations must have a documented need for the services and the services must be determined medically appropriate, as further described in STC 9.6, for the documented need. Medical appropriateness must be based on clinical and social risk factors. This determination must be documented in the beneficiary's care plan or medical record. The allowable targeted populations are:

a. Youth with Special Health Care Needs (YSHCN) ages 19-26 as described in STC 4.6;

b. Adults and youth discharged from an IMD, residential mental health and substance use disorder facility, or inpatient psychiatric unit;

c. Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities;

d. Youth involved in the child welfare system, including youth transitioning out of foster care;

e. Individuals transitioning from Medicaid-only to dual eligibility status;

f. Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; and

g. Individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon.

9.6. **Protocols for HRSN Infrastructure and HRSN Services.** The state must submit, for CMS approval, the Protocol for HRSN Infrastructure and the Protocol for HRSN Services. The state may not claim FFP for HRSN Infrastructure or HRSN Services expenditures until CMS approves the respective Protocol. Each Protocol may be submitted and approved separately. Once approved, the state may claim FFP for HRSN Infrastructure and HRSN Services expenditures retrospectively to the beginning of the demonstration approval date. The protocols for HRSN Infrastructure and HRSN Services may be updated as details are changed or added. The approved Protocols will be appended to the STCs as Attachment J.

a. The Protocol for HRSN Infrastructure must include proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

b. The Protocol for HRSN Services must include:

i. A list of the covered HRSN services (not to exceed those allowed under STC 9.2), with associated service descriptions and service-specific provider qualification requirements

ii. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable

iii. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate

i. Plan to identify medical appropriateness based on clinical and social risk factors

ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders

iv. A description of the process for developing care plans based on assessment of need

i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening

ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed

9.7. **Provider Network Capacity.** The state must require CCOs to ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid agency guidance.

9.8. **Contracted Providers.** The following requirements must be consistent with CCO and/or any other applicable vendor contracts and are applicable to all HRSN services.

a. The state must require CCOs and/or other applicable vendors to contract with HRSN service providers ("Contracted Providers") to deliver HRSN services authorized under the demonstration, as applicable.

b. The state must require CCOs and/or other applicable vendors to establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of their applicable HRSN services. Contracted Providers do not need to be licensed unless otherwise required by the state; however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

c. Any state direction on payment arrangements for HRSN services that constitutes a state directed payment must satisfy the requirements in 42 CFR 438.6(c).

9.9. **Service Delivery.** HRSN services will be provided both through the FFS system and through the state's existing CCO network. In accordance with STC 5.1, individuals who are not required to enroll into a CCO or who may disenroll from a CCO will receive HRSN services through a FFS delivery system.

a. HRSN services will be available from all CCOs and must be included in the managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

b. CCOs will provide all HRSN services authorized under this demonstration through contracted network providers.

c. CCOs must offer the services in all service areas in which the CCO operates.

d. It is permissible for HRSN services to be paid via a non-risk payment to the CCOs. For a non-risk payment, the CCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, HRSN services may be paid on a fee-for-service basis by the state as defined in 42 CFR 447.362. If the state chooses to instead

incorporate the HRSN services into risk-based capitation rates, it must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, and 438.7.

9.10. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

9.11. **Person-Centered Service Plan.** The state shall ensure that there is a person-centered service plan for each individual determined to be eligible for HRSN services. The person-centered service plan must be person-centered, identify the individual's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the individual and the individual's chosen support network as appropriate. The person-centered service plan will be reviewed and revised upon reassessment of need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

9.12. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state agrees that appropriate separation of assessment, service planning and service provision functions are incorporated into state, CCO, and other applicable vendors' conflict of interest policies.

9.13. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce availability of, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.

ii. Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if HRSN services were not an option.

iii. Medicaid beneficiaries always retain the right to file appeals and/or grievances pursuant to 42 CFR 438.

iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they have requested, are currently receiving, or have previously received HRSN services.

v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit data when requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken to inform health equity efforts and efforts to mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. The state must seek CMS approval on what is considered appropriate and reasonable timeframe for plan submission of encounter data. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken, to inform health equity efforts and efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state, or another legally authorized oversight body to aid in ongoing evaluation of HRSN services or any independent assessment or analysis conducted by the state, CMS, or another legally authorized independent entity.

iii. Any additional information determined reasonable, appropriate and necessary by CMS.

9.14. **Rate Methodologies.** All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to fee-for-service payment as well as non-risk payments and capitation rates in managed care delivery systems, as part of the New Initiatives Implementation Plan (see STC 13.4) at least 60 days prior to implementation. States must submit all documentation requested by CMS, including but not limited to the payment rate methodology as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting fee-for-service payment rates.

9.15. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for social services related to housing transition supports and nutrition supports for the duration of the demonstration. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the New Initiatives Implementation Plan (see STC 13.4) that outlines how it will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 13.6, including any justifications necessary to describe the findings.

9.16. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the person-centered plans as appropriate. The state will submit a plan to CMS as part of the New Initiatives Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly Monitoring Reports described in STC 13.6, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Quarterly Monitoring Reports.

10. REENTRY DEMONSTRATION INITIATIVE

10.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid individuals and qualifying Children's Health Insurance Program (CHIP) individuals who are or would be eligible for CHIP if not for their incarceration status, who are residing in a state prison, county or regional jails, juvenile detention, or state youth correctional facility (hereinafter "correctional facility") as further specified in the STCs below.

10.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid and CHIP participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid and CHIP enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

i. Improve post-release physical and behavioral health of incarcerated members;

j. Promote continuity of medication treatment; and

k. Reduce health care costs by ensuring continuity of care upon release into the community.

10.3. **Qualifying Criteria for Pre-Release Services.** To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 10.1; and

b. Have been found eligible for Medicaid or CHIP or be otherwise eligible for CHIP if not for their incarceration status.

10.4. **Scope of Pre-Release Services**. The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation plan required under STC 10.10. The state may provide these services in-person or, as-needed, through telehealth.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs and health-related social needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. Limited clinical consultation services, as clinically appropriate;

iv. Diagnostic services, including laboratory and radiology services, and treatment services in addition to those identified in STC 10.4(a)(ii);

v. Prescribed drugs, in addition to those identified in STCs 10.4(a)(ii) and 10.4(b), and medication administration;

vi. Family planning services and supplies;

vii. Services provided by community health workers; and

viii. Peer support services.

b. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Similarly, for CHIP, the expenditure authority for pre-release services constitutes a limited exception to the general exclusion of children who are inmates of a public institution from the definition of a targeted low-income child under section 2110(b)(2)(A) of the Act ("child exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule or an exception in section 2110(b)(7) of the Act to the child exclusion rule, effective January 1, 2025, remain subject to the inmate exclusion rule or the child exclusion rule, as applicable. Accordingly, other benefits and services covered under the Oregon Medicaid or CHIP State Plan(s), as relevant, that are not included in the above-described pre-release services benefit for qualifying Medicaid or CHIP

individuals are not available to qualifying individuals through the Reentry Demonstration Initiative.

10.5. **Participating Correctional Facilities**. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to the Oregon Health Authority's approval of a facility's readiness, according to the implementation timeline described in STC 10.9. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

10.6. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Oregon scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as Medicaid or CHIP providers.

b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

10.7. **Suspension of Coverage**. Upon entry of a Medicaid or CHIP individual into a correctional facility, Oregon Health Authority must not terminate and generally shall suspend their Medicaid coverage or CHIP eligibility.

a. If an individual is not enrolled in Medicaid or CHIP when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid or CHIP and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

10.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children.** To the extent that Oregon's reentry demonstration initiative includes coverage otherwise required to be provided under section 1902(a)(84)(D) and section 2102(d)(2) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality or allotment neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

10.9. **Reentry Demonstration Initiative Implementation Timeline**. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). Oregon Health Authority will determine that each applicable facility is ready to participate in the Reentry Demonstration Initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 10.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable.

   Oregon will require participating facilities to select a Service Level for implementation. Service Level One consists of the required pre-release services as indicated in the State Medicaid Director Letter (SMDL) #23-003 and identified in STC 10.4.a and b, and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable.

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments and managed care plans.

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid or CHIP state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;

g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h. Reporting of data requested by Oregon Health Authority to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

10.10. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the SMDL (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment P titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the Reentry Demonstration Initiative starting from the date of inclusion of the Implementation Plan as an attachment to these STCs.

10.11. **Reentry Demonstration Initiative Reinvestment Plan**. To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment Q). The Reinvestment Plan will define the amount

of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment Q the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

    v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

    vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

    vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment Q) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment Q titled "Reentry Demonstration Initiative Reinvestment Plan."

10.12. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid and CHIP pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid and CHIP pre-release applications In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among Oregon Health Authority and Qualified Applicants listed in STC 10.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid and CHIP. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry Demonstration Initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g., for inmates who would be eligible for CHIP but for their incarceration status and coordinating pre-release and post-release services for enrollees). This includes the development of electronic interfaces for Qualified Applicants listed in STC 10.12(d). to communicate with Medicaid and CHIP IT systems to support Medicaid and CHIP enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 10.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 10.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid and CHIP enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid and CHIP enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among Oregon's Qualified Applicants in STC 10.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid and CHIP; (2) assisting with the completion of a Medicaid or CHIP application; (3) submitting the Medicaid or CHIP application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth

in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 7. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 14.12, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 7. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 21	DY 22	DY 23	DY 24	DY 25
Total Computable Expenditures	$0	$17,325,000	$57,750,000	$40,425,000	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid/CHIP Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid/CHIP agency.

11. TRADITIONAL HEALTH CARE PRACTICES

11.1. **Traditional Health Care Practices Program Overview.** This component of the demonstration will provide federal financial participation (FFP) for state expenditures on traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), and facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization or UIO facilities) by Medicaid and CHIP beneficiaries who are able to receive services by or through those facilities. Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under Expenditure Authority 14 and 18, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid- and CHIP-covered services; and

3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per STC 13.6b the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

11.2. **Criteria for Receiving Coverage for Traditional Health Care Practices.** To receive coverage for traditional health care practices under this component of the demonstration, a beneficiary must meet the following criteria:

a. Is a Medicaid or CHIP beneficiary, and

b. Is able to receive services delivered by or through IHS, Tribal or UIO facilities, as determined by the facility.[5]

11.3. **Scope of Traditional Health Care Practices.** The state may claim FFP for its expenditures on any traditional health care practice that is delivered by or through an IHS, Tribal, or UIO facility to a beneficiary meeting the criteria in STC 11.2.

a. The state will be required to report traditional health care practices provided and utilization in the Annual Monitoring Report.

b. Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under Expenditure Authority 14 when those services are received through IHS and Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[6] State

[5] Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are eligible to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, UIO facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. UIO facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds.

[6] Section 1905(b) of the Social Security Act (third sentence).

expenditures for these services when delivered to Medicaid beneficiaries by UIO facilities, state expenditures for these services when delivered by or through qualifying facilities to CHIP beneficiaries, and state expenditures on these services when provided by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match.

c. Excluded items, services, and activities that are not covered as part of the scope of traditional health care practices include, but are not limited to:

   i. Construction costs (including building modification and building rehabilitation);

   ii. Room and board;

   iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting, except as described in expenditure authority 12;

   iv. Services provided to individuals who are not lawfully present in the United States or are undocumented;

   v. Capital investments; and

   vi. Research grants and expenditures not related to monitoring and evaluation.

11.4. **Participating Facilities.** Traditional health care practices are covered only when received through IHS, Tribal, or UIO facilities.

11.5. **Participating Providers.** Practitioners or providers of traditional health care practices must be employed by or contracted with IHS, Tribal, or UIO facilities, which could include an urban Indian organization contracted with an IHS or Tribal facility. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

11.6. **Payment Methodology.** The state must comply with the payment rate-setting requirements in 42 CFR Part 447, Subpart B, as though a state plan amendment were required, to establish a payment rate or methodology for traditional health care practices as approved through demonstration expenditure authority 14 and 18. The state must conduct state-level public

notice under 42 CFR 447.205 prior to using the applicable payment methodologies to pay for traditional health care practices and must maintain documentation of the payment methodologies on its website described in 42 CFR 447.203. The state is encouraged to engage with CMS on the development of all new and modified fee-for-service or non-risk rate contract payment methodologies if the state is not using the IHS All-Inclusive Rate (AIR)[7] when paying for traditional health care practices. Provided that all other requirements for claiming FFP have been met (including submission of the attestation described in STC 11.1), the state may draw FFP for traditional health care practices after using the payment methodologies to pay providers (and can use them to pay providers only subsequent to conducting notice under 42 CFR 447.205, as described above).

11.7. **Implementation Expenditures.** The state may claim FFP in its administrative and implementation expenditures to support the development and implementation of traditional health care practices:

a. This FFP will be available for state expenditures funding the following activities:

i. Technology: e.g., internal electronic referral systems, shared data platforms, electronic health record modifications or integrations, accounting and billing systems, data analytics and reporting;

ii. Development of business or operational practices to support delivery of traditional health care practices: e.g., procurement and planning, developing policies and workflows for managing referrals from other providers, privacy, evaluation, and beneficiary navigation;

iii. Workforce development: e.g., recruiting and training new staff, training staff on new policies and procedures; or

iv. Outreach, education, and community engagement: e.g., potential beneficiary engagement and coverage coordination, design and production of outreach and education materials, obtaining community input including through community convenings.

b. The state may claim FFP in traditional health care practices implementation expenditures for up to no more than the annual amounts outlined in Table 8. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year.

Table 8. Annual Limits of Total Computable Expenditures for Traditional Health Care Practices Implementation Expenditures

	DY21	DY22	DY23	DY24	DY25

[7] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

Total Computable Expenditures	$0	$0	$1,522,500	$1,522,500	$1,305,000

c. Traditional health care practices implementation expenditures must be claimed at the applicable administrative federal match rate.

d. Excluded items, services, and activities that are not covered as part of traditional health care practices implementation expenditures include, but are not limited to:

   i. Construction costs (including building modification and building rehabilitation);

   ii. Room and board;

   iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting, except as described in expenditure authority 12 and 17;

   iv. Services provided to individuals who are not lawfully present in the United States or are undocumented;

   v. Capital investments; and

   vi. Research grants and expenditures not related to monitoring and evaluation;

e. This implementation funding is separate and distinct from any payment to managed care plans for delivery of traditional health care practices. The state must ensure that traditional health care practice implementation expenditures are not factored into managed care payments for delivery of traditional health care practices and that there is no duplication of funds.

f. To the extent the state requests any additional implementation funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

12. PROVIDER PAYMENT RATE INCREASE REQUIREMENT

12.1. The provider payment rate increase requirements described hereafter are a condition for both DSHP and HRSN expenditure authority as referenced in Expenditure Authorities 5, 6, and 7.

12.2. As a condition of approval and ongoing provision of FFP in DSHP and HRSN expenditures over this demonstration period of performance, DY21 through DY25, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the state's definition of primary care, behavioral health care, or obstetric care, as

relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

12.3. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this STC 12. Additionally, the state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this STC 12 (i.e., cost-shifting).

12.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this STC 12, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health services.

12.5. By December 31, 2022, and if the state makes fee-for-service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios if applicable for each of the three categories of services as these ratios are calculated for the state and service category as noted in the following sources:

i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); and

ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3); OR

b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 12.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019; and

iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

12.6. To establish the state's ratio for each service category identified in STC 12.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 12.5.a, if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 12.5.b using Medicaid managed care provider payment rate and utilization data.

12.7. In determining the ratios required under STC 12.5 and 12.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).

12.8. If the state is required to increase provider payment rates for managed care plans per STC 12.2 and 10.6, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

12.9. For the entirety of DY23 through DY25, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate at any time in DY21 for each service (including any facility and provider modifiers), and such rate will be in effect on the first day of DY23. A required payment rate increase for a delivery system shall apply to all services in a service category as defined under STC 12.4.

12.10. If the state uses a managed care delivery system for any of the service categories defined in STC 12.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY23 through DY25, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate for each service in DY21 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 12.4.

12.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY23 (or, as applicable, the first day of the first rating period that starts in DY23), the state will provide an alternative effective date and rationale for CMS review and approval.

12.12. The state will provide the information to document the payment rate ratio required under STC 12.5 and 12.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.

12.13. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

12.14. No later than December 31, 2022, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 12.5 and 12.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment K:

Oregon Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to provider payment rate increase requirements for the demonstration period of performance DY21 thru DY25		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 12.5.a or STC 12.5.b*]	[*insert approach, either ratio derived under STC 12.6.a or STC 12.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid*

		and Medicare to derive the ratio]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 12.5.a or STC 12.5.b*]	[*insert approach, either ratio derived under STC 12.6.a or STC 12.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 12.5.a or STC 12.5.b*]	[*insert approach, either ratio derived under STC 12.6.a or STC 12.6.b; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]

In accordance with STCs 11.1 through 11.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment rate increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY21, including any modifiers or qualifiers such as facility type, plus an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under a managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and provider types for each of these service categories in a manner consistent with other state and federal

Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under a managed care delivery system, the data and methodology for any one of the service categories as provided in STC 12.6.b will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b.*]
☐ a. The effective date of the rate increases is the first day of DY23 and will be at least sustained, if not higher, through DY25.
☐ b. Oregon has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing the provider payment rate increase on the first day of DY23. Oregon will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY25.

Oregon [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

Oregon [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, I agree to submit the Medicaid managed care plans' provider payment rate increase methodology, including the information listed in STC 12.7 through the state-directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*].

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 12.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

Oregon agrees not to use DSHP funding to finance any provider payment rate increase required under STC 12, and will ensure that the entirety of a two-percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans. Oregon further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 12.
I, *[insert name of SMD or CFO (or equivalent position*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide printed name of signatory* _____] [*Provide date*_____]

13. GENERAL REPORTING REQUIREMENTS

13.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in STC 13.1.b; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address

such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

If CMS agrees to an interim corrective process in accordance with STC 13.1.b, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

c. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

13.2. **Submission of Post-Approval Deliverables.** The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes as stipulated by CMS and within the timeframes outlined within these STCs.

13.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

13.4. **New Initiatives Implementation Plan.** The state is required to submit a New Initiatives Implementation Plan ("Implementation Plan") to cover certain key policies being tested under this demonstration, including those approved through any amendments. The Implementation Plan will contain applicable information for the following expenditure authorities: YSHCN, HRSN Infrastructure, HRSN Services, and Continuous Eligibility. The Implementation Plan, at a minimum, must provide a description of the state's strategic

approach to implementing these demonstration policies, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

The state must submit the Maintenance of Effort information required by STC 9.15 and 13.4.i for CMS approval no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted for CMS approval no later than 9 months after the approval of this demonstration. The state must submit any required clarifications or revisions to their Implementation Plan submission within 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment L and may be further altered only with CMS approval.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the demonstration policies that are not already captured in the STCs or available elsewhere publicly. Furthermore, for the state's HRSN-related authorities, the Implementation Plan does not need to repeat any information submitted to CMS in the Protocols for HRSN Infrastructure and HRSN Services (see STC 9.6); however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

The Implementation Plan does not need to duplicate information that pertains to more than one initiative, assuming the information is the same. The Implementation Plan can be updated as necessary to align with state operations. CMS may provide the state with a template to support the state in developing and obtaining approval of the Implementation Plan.

The New Initiatives Implementation Plan must include information on, but not limited to, the following:

a. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation

b. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries)

c. Plans for changes to information technology (IT) infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision.

d. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state

e. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs

f. A description of processes to perform verifications on beneficiary residency and other checks and to update beneficiary contact information on an annual basis, as described in STCs 4.5.d and e

g. A plan to finalize information as required by STC 4.6.a.v (YSHCN eligibility criteria)

h. Information as required per STC 9.14 (HRSN Rate Methodologies)

i. Information as required per STC 9.15 (MOE)

j. Information as required per STC 9.16 (Partnerships with State and Local Entities)

Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of authority for YSHCN, HRSN Infrastructure, HRSN Services, and/or Continuous Eligibility under this demonstration.

13.5. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment M. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

a. At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 13.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual

Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

b. For the HRSN services authorized through this demonstration, the Monitoring Protocol also requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines. This slate of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track performance relative to the goals and milestones, as provided in the implementation plan, for the HRSN infrastructure investments.

c. In addition, the state must describe in the Monitoring Protocol methods to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to: (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), and (4) social needs screening results from electronic health records, health plans, or other partner agencies, as applicable. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

d. In addition, the state must describe in the Monitoring Protocol methods and a timeline for collecting and analyzing non-Medicaid administrative data necessary to conduct comprehensive monitoring and evaluation of traditional health care practices. These sources may include but are not limited to data related to traditional health care practices provided by IHS, Tribal, or UIO facilities. Across data sources, in consultation with IHS, Tribal, and UIO facilities, the state must make efforts to collect data in ways that support subgroup analyses as appropriate.

e. For the qualitative elements (e.g., operational updates as described in STC 13.6), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

13.6. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct

information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. For the traditional health care practices demonstration component, Monitoring Reports must also include beneficiary grievances, complaints, and appeals related to the attestation described in STC 11.1.

    i. The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or

disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritize key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.

ii. For this demonstration's HRSN initiatives, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. In alignment with STC 9.16, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies to leverage their expertise and existing housing and nutrition resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

iii. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must – at a minimum – capture data on utilization of preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.

iv. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of disparities-sensitive metrics described above, with applicable demographic stratification. In addition, the state must demonstrate through its annual monitoring reporting to CMS improvements in Medicaid fee-for-service base provider reimbursement rates and reimbursement rates for providers enrolled in managed care to the extent required by STC 12.

v. As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use

monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives and the DSHP-funded initiatives.

vi. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 1.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology

vii. The state's selection and reporting of metrics for traditional health care practices are expected to include, but not be limited to: the number of facilities and providers providing traditional health care practices under the demonstration, the number of each type of traditional health care practice provided under the demonstration, and the number of individuals receiving traditional health care practices under the demonstration. In addition, the state must provide narrative updates on activities undertaken regarding allowable traditional health care practices implementation expenditures.

viii. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in STC 15, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately on the CMS-64.

d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

13.7. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

13.8. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

13.9. **Phase-out of Waiver Authority Related to the Prioritized List.** The state's waiver of amount, duration, and scope related to the Prioritized List, authorized in the original 1994 approval, will be phased out of the OHP demonstration by January 1, 2027. Use of this waiver authority will continue until January 1, 2027 while the state coordinates with CMS and its Legislature to authorize and implement its termination. Oregon will also be required to submit a phase-out plan that will assure all mandatory state plan benefits are available to eligible OHP beneficiaries. The plan must include activities the state will perform, during the demonstration period, that will effectuate the phase-out, including timelines for submission of any necessary state plan amendments, as described in STC 3.9.

a. **Phase-out Plan.** The state must submit a phase-out plan to CMS, no less than six months prior to the expiration of the relevant waiver of amount, duration, and scope on December 31, 2026. Prior to submission of the plan to CMS, the state must publish on its website, the draft phase-out plan for a thirty-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty-day public comment period has ended, the state must provide a summary of the comments received and any state changes to the phase out plan based on those comments. This Prioritized List Phase-Out Plan will be appended to these STCs as Attachment N.

13.10. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 17.7 and 17.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 13.1.

13.11. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

13.12. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

14. GENERAL FINANCIAL REQUIREMENTS

14.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable

demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

14.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

14.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

14.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

14.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

14.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider related-donations as defined by 42 CFR 433.52 are bona fide as defined by section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

14.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 13.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

14.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in STC 15:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

14.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

14.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. Table 9 provides a master list of MEGs defined for this demonstration.

Table 9. Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Parent Caretaker Relative (PCR)	Main	X		X	Medicaid-mandatory low-income families (Parents/Caretaker relatives and their children)
PWO	Main	X		X	Pregnant Individuals
CMO	Main	X		X	Children ages 0-18
BCCP	Main	X		X	Uninsured or underinsured under the age of 65

					receiving treatment services under the Breast and Cervical Cancer Treatment Program
Old Age Assistance	Main	X		X	Seniors age 65+; people with permanent disabilities
Aid to Blind/ Disabled	Main	X		X	Blind and Disabled Individuals
Foster Children	Main	X		X	Foster Children
Supplemental Vision/Dental Coverage for Tribes	Main			X	
Designated State Health Programs	Main			X	
ACA Adults	Hypo	X		X	Low-income adults at 0%-133% FPL
YSHCN	Hypo	X		X	Youth age 19-26 with multiple chronic health care needs
Continuous Eligibility (CE) PCR	Hypo	X		X	Medicaid-mandatory low-income families (Parents/Caretaker relatives and their children)
CE PWO	Hypo	X		X	Pregnant Individuals
CE CMO	Hypo	X		X	Children ages 0-18
CE BCCP	Hypo	X		X	Uninsured or underinsured under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program
CE Old Age Assistance	Hypo	X		X	Seniors age 65+; people with permanent disabilities
CE Aid to Blind/ Disabled	Hypo	X		X	Blind and Disabled Individuals
CE Foster Children	Hypo	X		X	Foster Children
HRSN Services	Capped Hypo		X	X	Health-Related Social Needs services
HRSN Infrastructure	Capped Hypo		X	X	Infrastructure costs related to the provision of HRSN services
ADM	N/A				All additional administrative costs that are directly

					attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.
MAGI Expanded Adult Program	Hypo	X		X	Adults ages 19-64 with incomes from 133% up to and including 200% FPL
Expanded Adult Program for Individuals who are Exempt from Managed Care	Hypo	X		X	Adults ages 19-64 with incomes from 133% up to and including 200% FPL who meet the criteria to be exempt from mandatory managed care enrollment in section 1932(a)(2) (C) of the Act and who are not eligible for Medicare or any other minimum essential coverage (as that term is defined in the ACA)
Reentry Initiative Services	Hypo	X		X	See Expenditure Authority #12
Reentry Initiative Non-Services	Hypo		X	X	See Expenditure Authority #13
Traditional health care practices implementation expenditures	Main			X	See Expenditure Authority #15

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

14.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00415/10). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in Table 9 as WW must be reported for expenditures, as further detailed in Table 10. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on Table 9 or in STC 154, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in STC 132.6, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in Table 9, and as also indicated in Table 10, with the exception of the Continuous Eligibility (CE) MEGs. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute

two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information. CE MEGs will report a calculated number of member months. Each CE MEG will report a percentage of the actual member months of the corresponding non-CE MEG. The corresponding non-CE MEG member months will then be reduced by the same percentage. For the CE CMO and CE Foster Children MEGs, this percentage will be 0.11%. For all other CE MEGs, this percentage will be 2.6%. For example, the actual member months for the Pregnant Individuals MEG will be reduced by 2.6 percent and the equivalent member months will be reported on the CE Pregnant Individuals MEG so that the total member months between the two MEGs are equal to the actual member months for the Pregnant Individuals group.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 10. MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
PCR	Medicaid-mandatory section 1931 low-income families (Parents, Caretaker relatives, and their children)	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
PWO	Pregnant Individuals	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CMO	Children 0-18	Follow CMS 64.9 Base	Date of service	MAP	Y	10/1/2022	09/30/2027

		Category of Service Definition					
BCCP	Uninsured or underinsured under the age of 65 receiving treatment under services for the Breast and Cervical Cancer Treatment Program (BCCTP)	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
Old Age Assistance	Seniors age 65+; people with permanent disabilities	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
Aid to Blind/ Disabled	Aged, Blind and Disabled	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
Foster Children	Foster care/ Substitute Care Children (Youth to age 26, if already in Oregon Foster Care; Youth to age 18, if in the Oregon Tribal Foster Care)	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
ACA Adults	Low-income expansion adults	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
YSHCN	Youth ages 19-26 with multiple chronic health care needs	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE PCR	Medicaid-mandatory section	Follow CMS 64.9	Date of service	MAP	Y	10/1/2022	09/30/2027

	1931 low-income families (Parents, Caretaker relatives, and their children) who are eligible via Continuous Eligibility	Base Category of Service Definition					
CE PWO	Pregnant Women who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE CMO	Children 0-18 who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE BCCP	Uninsured or underinsured under the age of 65 receiving treatment under services for the Breast and Cervical Cancer Treatment Program (BCCTP) who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE Old Age Assistance	Seniors age 65+; people with permanent disabilities who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE Aid to Blind/ Disabled	Aged, Blind and Disabled who are eligible via Continuous Eligibility	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2022	09/30/2027
CE Foster Children	Foster care/ Substitute Care	Follow CMS 64.9	Date of service	MAP	Y	10/1/2022	09/30/2027

	Children (Youth to age 26, if already in Oregon Foster Care; Youth to age 18, if in the Oregon Tribal Foster Care) who are eligible via Continuous Eligibility	Base Category of Service Definition					
HRSN Services	Report all expenditures for HRSN initiatives, excluding infrastructure	Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ ADM	N	10/1/2022	09/30/2027
HRSN Infrastructure	Report all expenditures for HRSN infrastructure	Follow standard CMS 64.10 Category of Service Definitions	Date of service	ADM	N	10/1/2022	09/30/2027
ADM	Report additional administrative costs that are directly attributable to the demonstration, are not described elsewhere, and are not subject to budget neutrality	Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/2022	09/30/2027
MAGI Expanded Adult Program	Adults 19-64 with incomes from 133 up to and including 200 percent FPL, already enrolled in OHP and determined ineligible due to income restrictions	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	04/2020 23	12/31/2024
Expanded Adults Exempt from Managed Care	Adults aged 19-64 with household incomes from 133 up to and including 200 percent FPL, who meet the	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	07/01/2024	09/30/2027

	criteria to be exempt from mandatory managed care enrollment in section 1932(a)(2)(C) of the Act, and who are not eligible for Medicare or any other minimum essential coverage (as that term is defined in the ACA)						
Reentry Initiative Services	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state correctional facilities	Follow CMS 64.9 Base Category of Service Definition	Date of service	MAP	Y	1/1/2026	09/30/2027
Reentry Initiative Non-Services	Expenditures for planning and supporting the reentry demonstration initiative	Follow standard CMS-64.10 Category of Service Definitions	Date of service	ADM	N	Date of approval	09/30/2027
Traditional health care practices implementation expenditures	Implementation costs related to traditional health care practices	Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	10/16/2024	9/30/2027

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

14.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in Table 11.

Table 11. Demonstration Years		
Demonstration Year 21	October 1, 2022 to September 30, 2023	12 months
Demonstration Year 22	October 1, 2023 to September 30, 2024	12 months
Demonstration Year 23	October 1, 2024 to September 30, 2025	12 months
Demonstration Year 24	October 1, 2025 to September 30, 2026	12 months
Demonstration Year 25	October 1, 2026 to September 30, 2027	12 months

14.13. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the state's regular Title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the state to update this percentage to the more accurate figure, as supported by the state's proposed methodology and data.

14.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 14.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state's regular Title XIX FMAP rate.

14.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in STC 15. CMS will provide technical assistance, upon request.[8]

[8] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of

14.16. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

14.17. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

   The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

14.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once a demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new

demonstration approval.

expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 14.18.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration, are outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will only be made for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors (such as not aging data correctly) or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

    vi. High cost innovative medical treatments that states are required to cover; or,

    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

15. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

15.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, three Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

15.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 9 and Table 10. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

15.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual or CE calculated number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

15.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. Table 12 identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 12. Main Budget Neutrality Test

MEG	PC or Agg *	WOW Only, WW Only, or BOTH	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
PCR	PC	Both	$715.99	5.2%	$762.83	$802.50	$844.23	$888.13	$934.31
PWO	PC	Both	$2,160.20	5.2%	$2,301.51	$2,421.19	$2,547.09	$2,679.54	$2,818.88
CMO	PC	Both	$482.05	5.0%	$512.36	$537.98	$564.88	$593.12	$622.78
BCCP	PC	Both	$2,273.78	5.2%	$2,422.52	$2,548.49	$2,681.01	$2,820.42	$2,967.08

Table 12. Main Budget Neutrality Test									
MEG	**PC or Agg ***	**WOW Only, WW Only, or BOTH**	**Base Year DY20**	**Trend Rate**	**DY21**	**DY22**	**DY23**	**DY24**	**DY25**
Old Age Assistance	PC	Both	$700.37	4.3%	$738.22	$769.96	$803.07	$837.60	$873.62
Aid to Blind/ Disabled	PC	Both	$1,960.72	4.8%	$2,079.06	$2,178.85	$2,283.43	$2,393.03	$2,507.90
Foster Children	PC	Both	$802.34	5.0%	$852.80	$895.44	$940.21	$987.22	$1,036.58
Supplemental Vision/Dental Coverage for Tribes	Agg	WW only	N/A	N/A	$1,034,000	$1,069,156	$1,105,507	$1,143,095	$1,181,960
Designated State Health Programs	Agg	WW only	N/A	N/A	$51,000,000	$182,000,000	$143,000,000	$159,000,000	$0
Traditional health care practices implementation expenditures	Agg	WW only	N/A	N/A	The state must have savings to offset these expenditures.				

*PC – Per Capita; Agg – Aggregate

15.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could

have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

15.6. **Hypothetical Budget Neutrality Tests.**

a. **Hypothetical Budget Neutrality Test 1: ACA Adults.** Table 13a identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13a. Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
ACA Adults	PC	Both	$709.82	5.5%	$758.95	$800.69	$844.73	$891.19	$940.21

b. **Hypothetical Budget Neutrality Test 2: YSHCN.** Table 13b identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13b. Hypothetical Budget Neutrality Test 2									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year DY20**	**Trend Rate**	**DY21**	**DY22**	**DY23**	**DY24**	**DY25**
YSHCN	PC	Both	N/A	4.8%	$0.00	$752.60	$788.73	$826.59	$866.27

c. **Hypothetical Budget Neutrality Test 3: Continuous Eligibility.** Table 13c identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13c. Hypothetical Budget Neutrality Test 3									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year DY20**	**Trend Rate**	**DY21**	**DY22**	**DY23**	**DY24**	**DY25**
CE PCR	PC	Both	$715.99	5.2%	$762.83	$802.50	$844.23	$888.13	$934.31
CE PWO	PC	Both	$2,160.20	5.2%	$2,301.51	$2,421.19	$2,547.09	$2,679.54	$2,818.88
CE CMO	PC	Both	$482.05	5.0%	$512.36	$537.98	$564.88	$593.12	$622.78
CE BCCP	PC	Both	$2,273.78	5.2%	$2,422.52	$2,548.49	$2,681.01	$2,820.42	$2,967.08
CE Old Age Assistance	PC	Both	$700.37	4.3%	$738.22	$769.96	$803.07	$837.60	$873.62
CE Aid to Blind/ Disabled	PC	Both	$1,960.72	4.8%	$2,079.06	$2,178.85	$2,283.43	$2,393.03	$2,507.90
CE Foster Children	PC	Both	$802.34	5.0%	$852.80	$895.44	$940.21	$987.22	$1,036.58

CE – Continuous Eligibility

d. Hypothetical Budget Neutrality Test #4: MAGI Expanded Adult Program and Expanded Adults Exempt from Managed Care populations. Table 13.d identifies the MEGs used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13d. Hypothetical Budget Neutrality Test 4									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year DY21**	**Trend Rate**	**DY21**	**DY22**	**DY23**	**DY24**	**DY25**
MAGI Expanded Adult Program	PC	Both	$709.82	5.5%	$758.95	$800.69	$844.73	$891.19	$940.21
Expanded Adults Exempt from Managed Care	PC	Both	$986.64	5.5%	--	$1,040.90	$1,098.15	$1,158.55	$1,222.27

e. **Hypothetical Budget Neutrality Test #5: Reentry Demonstration Initiative Expenditures**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13e: Hypothetical Budget Neutrality Test 5								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21**	**DY 22**	**DY 23**	**DY 24**	**DY 25**

Reentry	PC	Both	5.1%	$0	$0	$1,200.28	$1,261.49	$1,325.83
Reentry Non-Service	Agg	Both	N/A	$0	$17,325,000	$57,750,000	$40,425,000	$0

15.7. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (as specified in STC 9), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives (per STC 9.3); this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP provided under section 1115(a)(2) in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

15.8. **Capped Hypothetical Budget Neutrality Test: HRSN.** Table 14 identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 14. Capped Hypothetical Budget Neutrality Test							
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**DY21**	**DY22**	**DY23**	**DY24**	**DY25**
HRSN services	Agg	Both	$0M	$223M	$227M	$227M	$227M
HRSN Infrastructure	Agg	Both	$51M	$53M	$5M	$5M	$5M

15.9. **Monitoring Budget Neutrality for Traditional Health Care Practices.** As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authorities. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS AIR. CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit of the demonstration. Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.6. This amendment includes the addition of a "with waiver" only expenditure authority for implementation expenditures which will be paid for with demonstration savings. The state must still report quarterly claims and report expenditures on the CMS 64.9 form.

15.10. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end

of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

15.11. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from October 1, 2022 to September 30, 2027. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings, from up to 10 years of the immediately prior demonstration approval period(s) (July 1, 2012 to June 30, 2022). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

15.12. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) The savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 15.10, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $10,439,951,884.

15.13. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in Table 15 as a guide for determining when corrective action is required.

Table 15. Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY21	Cumulative budget neutrality limit plus:	2.0 percent
DY21 through DY22	Cumulative budget neutrality limit plus:	1.5 percent
DY21 through DY23	Cumulative budget neutrality limit plus:	1.0 percent
DY21 through DY24	Cumulative budget neutrality limit plus:	0.5 percent
DY21 through DY25	Cumulative budget neutrality limit plus:	0.0 percent

16. MONITORING ALLOTMENT NEUTRALITY

16.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for the title XXI funded Medicaid expansion population (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and the title XXI funded separate CHIP population (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 and CMS-64.21U waiver forms for each title XXI demonstration population.

c. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS-64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

16.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for the title XXI funded separate CHIP population and CMS-37 for the title XXI funded Medicaid expansion population. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the title XXI funded separate CHIP population and report demonstration expenditures for the title XXI funded Medicaid expansion population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS-64.21UP Waiver forms with federal funding previously made

available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

16.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 4 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

16.5. **Exhaustion of Title XXI Allotment for CHIP Populations.** If the state has exhausted title XXI funds, expenditures for the title XXI funded CHIP populations described in STC 4, and as approved within the CHIP state plan, may be claimed as title XIX expenditures. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the CHIP populations. The state shall report demonstration expenditures for these individuals, identified as population 4 in Attachment C, on the Forms CMS 64.9W and/or CMS 64.9P W.

17. EVALUATION OF THE DEMONSTRATION

17.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 13.1.

17.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed

to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

17.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

17.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment O to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

17.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

Specifically, evaluation hypotheses for the HRSN initiatives must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. Hypotheses must be designed to help understand, in particular, the impacts of Oregon's housing support and food assistance programs on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the OHP demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing and nutrition supports change over time in concert with new Medicaid funding toward those HRSN services.

In addition, in light of how demonstration HRSN expenditures are being treated for budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation

of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

For the continuous eligibility policy, the state must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility. For example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes. The state must also evaluate the effectiveness of the continuous eligibility authority. For example, for the state's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the state may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the state may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing certain home-and-community-based services or services to address HRSN or behavioral health. Evaluation hypotheses must also address CCO's efforts to integrate behavioral, oral, and physical health, promote value-based care, and support cost-effective, quality health care to beneficiaries, and must further focus on the impact of passively enrolling FFS-eligible beneficiaries in CCOs.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must analyze the budgetary effects of the HRSN services, as well as the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the continuous eligibility and the HRSN demonstration components, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the

demonstration design process and whether specific factors acted as facilitators of or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

Evaluation of the traditional health care practices demonstration initiative must be designed to examine whether the initiative increases access to culturally appropriate care for beneficiaries served by or through IHS, Tribal, or UIO facilities. In evaluating the effectiveness of the initiative, the state must capture the perspectives of IHS, Tribal, and UIO facilities through qualitative data collection efforts. The state is also strongly encouraged to consult with IHS, Tribal, and UIO facilities, participating providers, and beneficiaries in the development of the evaluation design. The evaluation must address topics that include but are not limited to: beneficiary awareness and understanding of traditional health care practices; reasons for individuals receiving the traditional health care practices; access to, utilization

and costs of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. The state's evaluation efforts must facilitate understanding the extent to which the traditional health care practices initiative might support reducing existing disparities in access to and quality of care and health outcomes.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

17.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

17.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

The Interim Evaluation Report must comply with Attachment B of these STCs.

17.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS of the draft.

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within 30 calendar days.

17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

17.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.

17.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

17.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

18. SCHEDULE OF THE STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
No later than 90 days after demonstration approval	Approved DSHP List	STC 8.1
No later than 150 calendar days after demonstration approval	DSHP Claiming Protocol	STC 8.4
No required submission date; FFP for HRSN infrastructure and HRSN services is contingent on CMS approval of these deliverables (separately)	Protocols for HRSN Infrastructure and HRSN Services	STC 9.6
No later than nine months after demonstration approval	Draft New Initiatives Implementation Plan	STC 13.4
No later than 60 days after receipt of CMS comments	Revised New Initiatives Implementation Plan	STC 13.4
No later than 150 calendar days after demonstration approval	Draft Monitoring Protocol	STC 13.5
No later than 60 days after receipt of CMS comments	Revised Monitoring Protocol	STC 13.5
No less than six months prior to the expiration of the waiver of amount, duration, and scope related to the Prioritized List on December 31, 2026	Prioritized List Phase-out Plan	STC 13.9
No later than 120 calendar days after the expiration of the demonstration	Close-Out Report	STC 13.10
No later than 30 days after receipt of CMS comments	Revised Close-Out Report	STC 13.10
180 days after approval	Draft Evaluation Design	STC 17.3
No later than 60 days after receipt of CMS comments	Final Evaluation Design	STC 17.4
One year prior to current expiration date, September 30, 2027, or when the extension application is submitted, whichever is sooner	Draft Interim Evaluation Report	STC 17.7
No later than 60 days after receipt of CMS comments	Revised Interim Evaluation Report	STC 17.7
No later than 18 months after the end of the demonstration period (September 30, 2027)	Draft Summative Evaluation Report	STC 17.8

No later than 60 days after receipt of CMS comments	Revised Summative Evaluation Report	STC 17.8
Annually		
Annually (included in Annual Monitoring Reports)	State Quality Strategy	STC 5.8
No later than October 1st and 90 days after the end of each DY thereafter	Annual Monitoring Reports	STC 13.6
No later than 6 months after the demonstration's implementation and annually thereafter	Post Award Forum	STC 13.11
Quarterly		
Quarterly	Quarterly Monitoring Reports	STC 13.6
Quarterly	CMS-64 Expenditure Reports	STCs 13-15

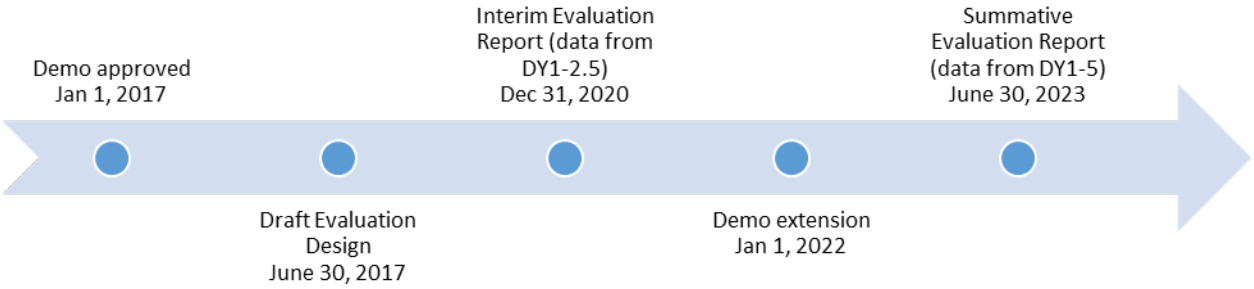
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations.

The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or

post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).

b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-

standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

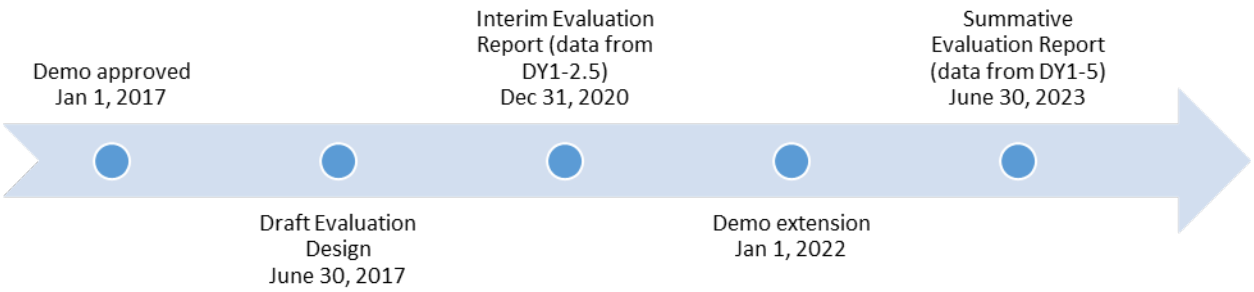
3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports
The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.
    4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
    5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
    1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
    2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
    3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
    4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration

and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C
Summary Chart of Populations Affected by or Eligible Under the Demonstration

I. Mandatory Medicaid Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
1	Pregnant Individuals	Title XIX	Title XIX state plan and section 1115	0% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL* Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1
4	Children 0 through 18	Title XXI	Title XXI state plan and section 1115	>133% up to 300% FPL	None	OHP Plus	Base 1
6	Medicaid mandatory section 1931 low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and section 1115; and those Dually	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	Base 2

			Eligible for Medicare and Medicaid				
8	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus	Base 2
21	Uninsured or underinsured under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program (BCCTP)	Title XIX	Title XIX state plan and section 1115	Eligibility will be determined according to the state plan criteria.	None	OHP Plus	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX state plan and section 1115	0% up to 133% FPL	None	ABP (OHP Plus)	Base 2

*Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the state also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by federal regulations, since the state has chosen to extend Medicaid coverage to pregnant individuals up to 185 percent of the FPL.

II. Optional Medicaid Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	$2,000	OHP Plus	Base 2
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1

10	Youth with Special Health Care Needs (Youth transitioning to adulthood, age 19-26)	Title XIX	Title XIX state plan and section 1115	>133% to 300% FPL	None	OHP Plus	YSHCN
24	MAGI Expanded Adult Program	Section 1115	Section 1115	133% through 200% FPL	None	OHP Plus excluding HRSN and LTSS as outlined in STCs 4.2.c.ix and 9.5	MAGI Expanded Adult Program
25	Expanded Adults Exempt from Managed Care	Section 1115	Section 1115	133% through 200% FPL	None	OHP Plus excluding HRSN and LTSS as outlined in STCs 4.2.c.ix and 9.5	Expanded Adults Exempt from Managed Care

ATTACHMENT D
Model Tribal Engagement and Collaboration Protocol

A. Definitions

1. Indian or American Indian/Alaska Native (AI/AN). Indian and/or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).

2. Traditional Health Workers (THW). THW is defined as provided under OAR 410-180-0300 through 410-180-0380.

3. Tribe. Tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

4. Tribal Organization. Tribal organization means the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: *Provided*, that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant

5. Urban Indian Health Program (UIHP). Urban Indian Health Program means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.

6. Indian Health Care Provider (IHCP). Indian Health Care Provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

B. General Provisions

1. **Tribal Consultation Policy.** The state will continue to follow the Tribal Consultation and Urban Confer Policy related to activities under this demonstration.

2. **Tribal Technical Advisory Board.** Through ongoing communications (e.g., emails) and during a standing meeting on a quarterly basis, the state will solicit advice and guidance from the Board on policies, guidelines, and programmatic issues affecting the delivery of health care for tribal members and to ensure that Indians receive quality care and access to services. The role of the Tribal Technical Advisory Board will be included in the Tribal Consultation Policy and is not meant to replace the tribal consultation process.

3. **Formal Linkages.** Formal linkages between the tribes, UIHP and CCO networks will continue to be developed, and the tribes and UIHP will take an active role in advising the state around improvements to ensure effective collaboration between tribes, UIHP, health care providers, and CCOs. This collaborative effort between the various tribal and health care delivery system partners will positively affect access to health care services and provider reimbursements.

4. **Medicaid Issues Resolution**. State will create a list of designated contacts to work with IHCPs to resolve issues with managed care and fee for service (FFS) related to enrollment, prior authorization processing, billing, claims, and payment as issues arise for the IHCP.

5. **Mandatory and Optional Benefits.** Notwithstanding any other provision in this demonstration, the state may reimburse tribal health programs for all Mandatory and Optional benefits in the Medicaid State Plan.

6. Transformation Center. IHCPs will have access to Transformation Center supports, including but not limited to, access to targeted technical assistance on behavioral and physical health integration and technical assistance and participation in Oregon's Project Extension for Community Healthcare Outcomes (ECHO) initiative, which is a national tele-mentoring model that provides primary care providers an opportunity to learn from specialists to better manage complex conditions and patients in their practices.

7. Health Information Technology Efforts. IHCPs will have opportunities around engagement and participation in Health IT projects and programs sponsored by the state, including but not limited to technical assistance; health information exchange; provider data; and the Medicaid Electronic Health Record Incentive Program. As OHA develops Health Information Technology strategies, the state will continue to involve tribes. See the attachment for further information on HIT projects and programs.

C. Coordinated Care Organizations

1. Contracts with IHCP. The CCOs are required to offer contracts to all Medicaid eligible IHCPs (as set forth below in STC 2 – Model IHCP Addendum) and to provide timely access to specialty and primary care within their networks to CCO-enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the CCO/MCO network.

2. Model IHCP Addendum (see Appendix A). Any contract between the state and a CCO under Oregon's 1115 demonstration shall require the CCO to offer contracts to all IHCPs in the area they serve using, at a minimum, the provisions in the CMS "Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)" approved by the tribes and UIHP (Model IHCP Addendum in Appendix A). CCOs will be required to adopt either the Model IHCP Addendum or an addendum agreed upon in writing by the CCO and every tribe and Indian Health Care Provider (IHCP) in the CCO's region. The Model IHCP Addendum or alternate addendum to be used by CCOs will assure that CCOs comply with key federal laws that apply when contracting with IHCP providers, minimize potential disputes, and lower the perceived barriers to contracting with IHCP. IHCPs may agree to include additional provisions in the Model IHCP Addendum.

3. Timeline for Contracts with CCOs. CCOs and IHCPs interested in entering into a contract will reach an agreement on the terms of the contract within six months, unless an extension is agreed upon by both parties. If the CCO and IHCP do not reach an agreement on the terms of the contract within six months, the IHCP may request the assistance of a state representative to assist with negotiation of the contract with a CCO. The state will use the informal process to facilitate an in-person meeting with the CCO and IHCP to assist with the resolution of issues and to facilitate an agreement between the CCO and IHCP. If an informal process does not lead to an agreement, the CCO and IHCP will use the existing dispute resolution process (OAR 410-141-3269), which will be used as guidance and will not be binding on the IHCPs. The state will use the existing process to facilitate an in-person meeting with the CCO and IHCP to assist with resolution of issues between CCO and IHCP and to facilitate an agreement between the CCO

and IHCP. The CCOs and IHCP must finalize and approve the contract within 60-90 days of reaching an agreement.

4. **No Obligation for IHCP to Contract.** IHCP are under no obligation to contract with CCOs or plans.
5. **Community Health Needs Assessment (CHA).** Beginning with the 2019 CCO contracts and ongoing, the state will require CCOs to 1) include tribes and IHCP in the area to gather and contribute data on health disparities; 2) allow IHCPs to review and provide input on the CCO's community health needs assessment; and 3) provide tribes and IHCP with the final community health needs assessment, including data relevant to the tribal population. The state will encourage the CCOs to include the tribes and IHCP in the CHA process, as described above, upon approval of the tribal protocol in 2017.
6. **Community Health Improvement Plan (CHIP).** Beginning with the 2019 CCO contracts, the state will require CCOs to 1) engage IHCP participation in the CCO's process to identify the Community Health Improvement Plan priorities; and 2) allow IHCPs to review and provide feedback to the draft Community Health Improvement Plan before it goes to the CCO board for approval; IHCP review and feedback will need to occur in a timeframe that does not delay CCO approval processes for the CHIP. The state will encourage the CCOs to include tribes and IHCPs in the CHIP process, as described above, upon approval of the tribal protocol in 2017 and ongoing.
7. **Cost Sharing.** Any contract between the state and a CCO shall prohibit the CCO from imposing any enrollment fee or premium on an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under Purchase/Referred Care (PRC). No deductible, copayment, coinsurance or similar cost sharing for any Medicaid covered service shall be imposed against an AI/AN who has ever been furnished an item or service directly by the IHCP or through referral under contract health services. Payments due to the IHCP or through PRC for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.
8. **IHCP Network Adequacy.** As referenced in 42 CFR 438.14(b)(1) and §457.1209, any contract between the state and a CCO must require the CCO guarantee that there are a sufficient number of IHCPs in the network to ensure timely access to Medicaid services for Indian enrollees eligible to receive such services.
9. **Payment requirements.** a. Per 42 CFR 438.14(c)(1) and §457.1209, when an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the CCO, it must be paid an amount equal to the amount the CCO would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the CCO pays and what the IHCP FQHC would have received under FFS.
    b. Per 42 CFR 438.14(c)(2) and §457.1209, when an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of CCO entity or not, it has the right to receive its applicable encounter rate published annually in the **Federal Register** by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.
    c. Per 42 CFR 438.14(c)(3) and §457.1209, when the amount an IHCP receives from a CCO is less than the amount required by paragraph (b) of this subsection, the state must make a supplemental payment to the IHCP to make up the difference between the amount the CCO entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

10. **Timely Payment to IHCP Providers.** CCOs and/or state must make timely payments to IHCP whether such IHCP is a participating provider or non-participating provider. Under this section, timely payments means that IHCP must be paid the agreed upon rate with a CCO within 30-90 calendar days of billing, as referenced in OAR 410-141-320 (rule subject to change which may alter requirement for timely payment).
11. **IHCP Right of Recovery.** The state affirms its agreement to comply with Section 206 of the Indian Health Care Improvement Act (IHCIA) as codified in 25 U.S.C. § 1621e, and with 42 CFR 438.14 regarding the right to payment of IHCPs, and will take all reasonable actions to require the CCOs to comply with said provisions in a timely manner.
12. **No Auto-Assignment for Indians.** Auto-assignment will not apply to Indians, and they will be eligible to select an IHCP as their primary care provider whether they opt into managed care or not.
13. **Non-participating IHCP Referral.** As required by 42 CFR 438.14(b)(6), CCOs must permit out-of-network IHCPs to refer a CCO-enrolled Indian to a network provider for covered services without having to obtain a referral from a participating CCO provider.
14. **Exemption of Certain Property from Resources for Medicaid and CHIP Eligibility.** Notwithstanding any other provision in this waiver, the state shall disregard the property listed in 42 U.S.C. 1396a(ff) from resources for the purposes of determining the eligibility of an individual who is an Indian for
    medical assistance under Oregon's 1115 demonstration.
15. **Care Coordination:** Several tribes and UIHP are developing or implementing strategies to support enhanced care coordination given Oregon's health system transformation, CCO development, and recent CMS February 26, 2016 State Health Official letter expanding federal funding for services received through IHS or Tribal facility. In partnership with tribes, the state is exploring expanded opportunities for effective care coordination for Indians. The state will continue to collaborate with the IHCPs on delivery of care coordination services to Indians in Oregon.
16. **Corrective Action.** The state will engage in corrective action with a CCO and subject a CCO to penalties or other appropriate sanction, as set forth in the CCO-state agreement or administrative rules if: the CCO fails to perform any obligation under the CCO-state Agreement; or the CCO fails to ensure
    that eligible Indians are afforded timely access to care, rights, and benefits an IHCP's right to timely payment.
17. **CCO Tribal Liaison**. The state will continue to require CCOs to designate a Tribal Liaison to facilitate resolution of any issue between the CCO and an IHCP. The Tribal liaison's function may be an additional duty assigned to existing CCO staff. The CCO will make the Tribal liaison available for training by tribes and UIHP in the CCO's service area.
18. **Conflict Resolution.** The state will work with the IHCP to develop a process for conflict resolution which will include a provision for IHCP to submit concerns to the state regarding issues not resolved between the IHCP and CCO; and assist with facilitation and resolution of issues.
19. **Historical Trauma/Intergenerational Trauma and Cultural Competency.** The tribes and UIHP will work with the state tribal liaisons workgroup to develop and review the training on working with tribal governments and Indian communities. The training will include content on tribal governments, historical trauma and intergenerational trauma and promote cultural competency. Once it is developed, it will be provided as online training to CCOs and providers. After completing the training, CCOs will be able to apply the acquired knowledge and principles that are foundational to working with and understanding tribes and Indian communities.

D. Fee for Service (FFS)

1. Indian Individuals Excluded from Managed Care. Individuals identified as Indian are excluded from managed care unless an individual chooses to opt into managed care and access coverage pursuant to all the terms and conditions of Oregon's 1115 demonstration. Individuals who are Indian and who have not opted into managed care will receive the Medicaid services generally available to them through a fee-for-service (FFS) system under the Medicaid State Plan.

2. Notices. Any notice regarding enrollment in a plan under Oregon's 1115 demonstration must include information explaining that Indians are excluded from managed care unless they opt-in and that Indians who have not opted in may still receive services through a FFS system, with access to covered benefits through an IHCP.

3. Cost Sharing. No enrollment fee or premium shall be imposed on an Indian who is eligible to receive or has received an item or service furnished by an IHCP or through referral under purchased and referred care (PRC). No deductible, copayment, coinsurance or similar cost sharing for any Medicaid covered service shall be imposed against an Indian who has ever been furnished an item or service directly by the IHCP or through referral under contract health services. Payments due to the IHCP or through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

4. Fee-for-Service Access Monitoring Plan Data for Indians. Data gathered by the state related to state's requirement will be shared with IHCPs on a quarterly basis (or as often as required by law) to improve reporting and to address access issues for Indians.

Appendix A: Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the Managed Care Plan network IHCP agreement by and between_____(herein "Managed Care Plan") and ___(herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.[28]

28 Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

(a) "Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a

federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

• Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
• Is an Eskimo or Aleut or other Alaska Native;
• Is considered by the Secretary of the Interior to be an Indian for any purpose;
• Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(c) "Managed Care Plan" includes a Coordinated Care Organization (CCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or

instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).

(f) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

(g) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).

(h) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

/_/ IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments.

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is

 eligible for assistance under the Medicaid program may not be reduced by the amount of any

enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social

Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR

438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.

(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including

the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix B.

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.

(a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the Managed Care Plan network IHCP agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network IHCP agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network IHCP agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.

In the event of any dispute arising under the Managed Care Plan's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network IHCP agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed

and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. **Medical Quality Assurance Requirements.**
    To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675).
15. **Claims Format**.
    The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.
16. **Payment of Claims**.
    The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42
    U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c), and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.
17. **Hours and Days of Service.**
    The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.
18. **Coordination of Care/Referral Requirements.**
    The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.
19. **Sovereign Immunity**.
    Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.
20. **Endorsement.**
    IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:

Date: _____

For the IHCP:

Date: _____

_____

ATTACHMENT E
Coordinated Care Organizations Services Inventory

This attachment provides an inventory of included services into CCO global budgets and reflects OHA's planning as of October 2024.

Pursuant to STC 6.1.b.i., CCOs will be at risk for services included in the CCO Services Inventory, which are appended in this Attachment E. While the intent is to include as many services as possible within the global budget payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding any additional services to the global budget. For any services not paid as capitation, the state will identify the rate (referencing the state plan methodology or describing the rate methodology to CMS) and the rates will be subject to CMS review and approval.

	Program Area	Program Service Function	January 2023 (cont from previous waiver)	During 2022-2027 Waiver Period	Not Currently Planned
1	Addictions	OHP addiction health coverage for clients enrolled in managed care	X		
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X		
3	Mental Health	OHP mental health coverage for clients enrolled in managed care	X		
4	Mental Health	Children's Statewide Wraparound Projects	X		
5	Mental Health	Exceptional Needs Care Coordinators	X		

6	Mental Health	Non-forensic intensive treatment services for children (Inpatient Psychiatric Facility Services for Individuals Under age 21)	X		
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X		
8	Physical health care	OHP physical health coverage for clients enrolled in managed care (includes emergency transport)	X		
9	Mental Health	Supported Employment and Assertive Community Treatment	X		
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)			X
11	Addictions	Youth residential alcohol and drug treatment	X		
12	Addictions	Adult residential alcohol and drug treatment	X		

13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)			X

14	Targeted Case Management	HIV/AIDS Targeted Case Management			X
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon			X
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)			X
17	Transportatio n	Non-Emergent Medical Transportation	X		
18	Mental Health	Adult Residential Mental Health Services			X
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)			X
20	Dental	OHP dental coverage	X		
21	Mental Health	Young Adults in Transition Mental Health Residential			X
22	Mental Health	Personal Care 20 Client Employed Provider			X

23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)			X

24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)			X
25	Long Term Care	Long term care institutional and community supports			X
26	Mental Health	State Hospital Care – Forensic			X
27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations			X
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)			X

29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB			X
30	Mental Health	OHP-covered mental health drugs			X
31	Other	Hospital Leverages: GME, Pro-Share, and UMG			X

32	Other	FQHC Full-Cost Settlements (*exceptions specified in *Expenditure,* see also IHCP exception below)		
33	Other	A & B Hospital Facilities Settlements		
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)		
35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)		
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)		
37	Targeted Case Management	Tribal Targeted Case Management		
38	Other	Disproportionate Share Hospital Reimbursements		
39	Other	IHCP Full-Cost Encounter Rates	X	
40	Other	Health-Related Social Needs		X
41	Other	SUD Waiver Services (e.g. peer support)	X	

ATTACHMENT F
Approved DSHP List

Program	Description	DSHP-Eligible Expenditures
ODHS, Child Welfare, Family of Origin Supports	Mental health and mentoring services for parents of foster children and children in state custody	$1,024,691
ODHS, Child Welfare, FOCUS	Mentoring, respite, skills training, equine therapy, sex abuse treatment, transitional service, and other supportive services (tutoring) to support kids in foster care and maintain placement	$5,265,424
ODHS, Child Welfare, Other Medical	Services include non-Medicaid covered medical equipment and services such as assessments, drug screening, psych evaluations, and counseling.	$476,416
ODHS, Child Welfare, Strengthening, Preserving and Reunifying Families	Services for child welfare engaged families. Services include substance abuse supports and housing, kinship navigators, and in home parenting supports	$6,301,365
ODHS, Developmentally Disabled Services, SE #150 Family Support	Services include assistance in determining needed supports, respite care, purchase of adaptive equipment, personal care and other service	$41,661
OHA, HSD, M110/Marijuana Funding	Addiction Recovery Centers to provide health assessment, individual intervention plan/intensive case management, peer support, outreach. increase access to low barrier substance use disorder treatment, peer support, transitional, supportive and permanent housing, and harm reduction interventions.	$39,719,894
OHA, Non-Medicaid MH - SE05, Assertive Community Treatment Services (ACT)	Services aimed at keeping individuals in the community and out of a structured service setting for those with severe functional impairments who have not responded well to outpatient psychiatric treatment	$2,464,217
OHA, Non-Medicaid MH – SE06, Choice Model Services	Care coordination for adults with Serious Persistent Mental Illness (SPMI) that are not held to income or insurance standards. Services provided by a contractor include oversight and broad care coordination	$10,042,564

Program	Description	DSHP-Eligible Expenditures
OHA, Non-Medicaid MH - SE08/SE25A, Crisis and Acute Transition Services (CATS)	Services for youth and their families during transitions from emergency departments to community-based treatment and support services. Alternative for inpatient psychiatric admission when the child meets criteria to return home safely if support services are in place	$2,033,284
OHA, Non-Medicaid MH - SE13, School-Based Mental Health Services	School-based direct clinical services, care coordination, support, and training.	$2,444,648
OHA, Non-Medicaid MH - SE15, Young Adult Hubs Program (YAHP)	Services for marginalized young adults with mental health conditions who are disconnected from services or have no other resources to pay for service.	$1,363,759
OHA, Non-Medicaid MH – SE20, Non-Residential Community Mental Health Services for Adults, including housing support	Services delivered to individuals diagnosed with serious mental illness or other mental or emotional disturbance posing a danger to the health and safety of themselves or others.	$26,208,096
OHA, Non-Medicaid MH - SE25, Community Mental Health Crisis Services for Adults and Children (adults' mobile crisis)	Limited duration mental behavioral health crisis assessment, triage, and intervention for Individuals/families experiencing sudden onset psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning	$30,535,869
OHA, Non-Medicaid MH – SE38, Supported Employment Services	Supported employment services to individuals with chronic mental illness include supervision and job training, on-the-job visitation, consultation with the employer, job coaching, counseling, skills training, and transportation	$2,039,913
OHA, Public Health, Health Promotion/Chronic Prevention – Tobacco Prevention/Education Program	Tobacco use prevention, education, cessation, and interventions.	$8,625,955
Total DSHP-Eligible Expenditures		**$137,563,066**

ATTACHMENT G
DSHP Claiming Protocol

Reimbursement and Claiming Protocol for Oregon Designated State Health Programs Determination of Allowable DSHP Costs 11-W-00415/10

Acronyms:

- HSD – Health Systems Division
- ODHS - Oregon Department of Human Services
- OHA – Oregon Health Authority
- OHCS – Oregon Housing and Community Services
- OHP – Oregon Health Plan
- PCA – Program Cost Account
- PHD – Public Health Division
- SFMA – Statewide Financial Management Application

To support the goals of improving health outcomes and promoting health equity, the state may claim federal Financial Participation (FFP) for the following state programs subject to the annual limits and restrictions described in the Standard Terms and Conditions (STCs) #8 of Oregon Health Plan's (OHP) Waiver 11-W-00415/10 through September 30, 2027. This attachment contains the protocol for such determination of cost.

Office of Management and Budget (OMB) Circular A-87 (2 CFR Part 225), Cost Principles for state, Local and Indian Tribal Government requires federal grants be provided net of any applicable credits. The state is required to offset all revenues received relating to eligible expenditures identified under this attachment.

All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

CMS may review the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the program's financial status shall require the state to provide information to CMS about all sources of the non- federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

Below are descriptions of each DSHP program approved under waivers Waiver/Project Number 11-W-00415/10. The programs have been arranged based on program groups.

PROGRAM GROUP A: Programs for which all required program funding source information and data to determine expenditures eligible for DSHP may be obtained through a state agency accounting system (other than or in combination with the SFMA). The SFMA may be updated with information from one or a combination of these state sources: R*STARS, Oregon Buys, Workday, ORKIDS, VERSA.

Programs Included:

- ODHS, Child Welfare, Family of Origin Supports
- ODHS, Child Welfare, FOCUS
- ODHS, Child Welfare, Other Medical
- ODHS, Child Welfare, Strengthening, Preserving and Reunifying Families
- ODHS, Child Welfare, Client Transportation
- ODHS, Child Welfare, Family Preservation and Prevention
- ODHS, Child Welfare, Foster Care Prevention
- ODHS, Child Welfare, Foster Care Services
- ODHS, Child Welfare, Independent Living Services (ILS)
- ODHS, Child Welfare, System of Care/Temporary Lodging Prevention
- ODHS, Developmentally Disabled Services, SE #150 Family Support
- OHA, Non-Medicaid MH - SE05, Assertive Community Treatment Services (ACT)
- OHA, Non-Medicaid MH - SE08, Crisis and Acute Transition Services (CATS)
- OHA, Non-Medicaid MH - SE10, Mental Health Promotion and Prevention Services
- OHA, Non-Medicaid MH - SE11, Parent Child Interaction Therapy Services (PCIT)
- OHA, Non-Medicaid MH - SE13, School-Based Mental Health Services
- OHA, Non-Medicaid MH - SE15, Young Adult Hubs Program (YAHP)
    - OHA, Non-Medicaid MH - SE20, Non-Residential Community Mental Health Services for Adults, including housing support
    - OHA, Non-Medicaid MH - SE25/SE25A, Community Mental Health Crisis Services for Adults and Children (adult mobile crisis)
    - OHA, Non-Medicaid MH - SE26A, Non-residential Community Mental Health Services for Youth and Young Adults in Transition
- OHA, Non-Medicaid MH - SE35A, Older or Disabled Adult Community Mental Health Services GERO-Specialist
- OHA, Non-Medicaid MH - SE38, Supported Employment Services
- OHA, Public Health, Health Promotion/Chronic Prevention – Tobacco Prevention/Education Program
- OHCS, Energy Services, Electric Bill Payment Assistance (Oregon Energy Assistance Program-OEAP)

Funding Sources: Programs in this group may use a combination of state general funds (GF), other funds (OF) and grant funds (FF).

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #8. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

1. State identifies DSHP allowed program from Attachment F, from the statewide Financial Management Application (SFMA), the states' official Book of Record.

2. State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

    a. State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project

(number) and Grant (number) structures.

b. State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects, and Grants. Both the PCA and Index determine how the transaction will be posted to the agency's accounting structure.

c. State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will be posted.

3. State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

4. Source data systems access internal data and coding tables and assign accounting coding element structures based on entry data (i.e., coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

a. As payment documents are received, they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

5. For each program in this group that involves contractual services, the state must perform the following additional steps to determine the amount of the DSHP expenditure eligible for FFP under STC #8.

a. Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #8, paid to the vendor.

b. When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

6. Allowed DSHP expenditures, per STC #8, are paid to the provider of the service.

7. An additional 2% of expenditures is removed from the Direct Services total to account for services delivered to individuals who do not meet citizenship or immigration status requirements.

8. After these exclusions are deducted from the total expenditure amount, the DSHP eligible amount remains.

9. The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #8 and the individual DSHP program as allowed by Waiver 11-W-00415/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #8 are used for DSHP allowable program services.

Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure.

For each program in this group that involves contractual services, source data is from the R-Base database system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official 'book-of- record' for the state. The R- Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure.

Some programs may have contracts that are structured to pay service providers equal payments of 1/12th of the annual contracted amount. A reconciliation and settlement on these payments may be required by the contract after providers report on expenditures made. The cadence of the reporting and reconciliation can vary. If a settlement is required but still pending:

1. Prior period reconciliations are reviewed for each contract to determine what percentage of the contract has been spent by the provider.
    a. For new contracts, a comparable contract is used as a proxy to determine the initial percentage until historical data is available. If there is not a comparable contract, 95% is used as the initial percentage until historical data is available.
2. The state further reduces the historical percentages by 5 percent, and then by another 2 percent to reflect the reduction required for individuals who do not meet citizenship or immigration status requirements.
3. The state applies the resulting percentage to the amount of the 1/12th payment and claims this amount for DSHP.
4. After each agency reconciliation, the calculation is reviewed and adjusted as needed. During this reconciliation process, under-claiming of available DSHP-eligible expenditures could be claimed, and any over-claiming would be returned.

The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

Report Format: Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFMA accounting database.

PROGRAM GROUP B: Programs for which all funding sources for the program may be obtained

through the SFMA but for which external reporting is required to identify expenditures eligible for DSHP. The SFMA may be updated with information from a combination of these sources: R*STARS, Oregon Buys, Workday, and additional reporting requirements, described below.

Programs Included:

- OHA, HSD, M110/Drug Addiction Treatment and Recovery Act Funding
- OHA, Public Health, Public Health Modernization
- OHA, Non-Medicaid MH - SE06, Choice Model Services

Funding Sources: Programs in this group may use a combination of state general funds (GF), other funds (OF) and grant funds (FF).

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #8. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

1. State identifies DSHP allowed program from Attachment F, from the statewide Financial Management Application (SFMA), the states' official Book of Record.
2. State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.
    a. State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
    b. State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects, and Grants. Both the PCA and Index determine how the transaction will be posted to the agency's accounting structure.
    c. State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will be posted.
3. State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

4. Source data systems access internal data and coding tables and assign accounting coding element structures based on entry data (i.e., coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).
    1. As payment documents are received, they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.
5. For each program in this group that involves contractual services, the state must perform the following additional steps to determine the amount of the DSHP expenditure eligible for FFP under STC #8.

1. Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #8, paid to the vendor.
2. When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

6. Allowed DSHP expenditures, per STC #8, are paid to the provider of the service.
7. The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #8 and the individual DSHP program as allowed by Waiver 11-W-00415/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #8 are used for DSHP allowable program services.

Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure.

For each program in this group that involves contractual services, source data is from the R-Base database system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official 'book-of- record' for the state. The R- Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure.

The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

Report Format: Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFMA accounting database.

Program: OHA, HSD, M110/Drug Addiction Treatment and Recovery Act Funding

Specific to program processes steps: Oregon Ballot Measure 110 (M110) funds are being distributed to Behavioral Health Resource Networks (BHRNs) for substance use disorder

treatment and recovery through grant agreements. The BHRNs are then required to submit quarterly expenditure and programmatic data reports to OHA. Once expenditure reports are received, the data is automatically compiled and validated for analysis and external reporting, and the following steps are taken to extract DSHP eligible expenditures.

1. BHRN partners are instructed to allocate expenditures in two ways, into both budget categories and service areas. Note the total expenditure amount is to be equal between budget categories and service areas.
    a. These reports contain expenditure data categorized into the following 5 *budget categories*:
        i. Personnel Costs
        ii. Program Staff Training Costs
        iii. Services and Supplies Costs
        iv. Capital Outlay Costs
        v. Admin Costs.
    b. Additionally, the reports have a secondary categorization of the expenditure data by 7 *service areas:*
        i. Screening Assessments and Comprehensive Behavioral Health Needs Assessment
        ii. Individual Intervention Planning, case management and connection to services
        iii. Low Barrier Substance Use Disorder (SUD) Treatment
        iv. Peer support, mentoring, and recovery services
        v. Housing Services
        vi. Harm Reduction Intervention
        vii. Supported Employment

2. The expenditure data is then manually compiled into the categories described in the table below

Consolidated Expenditures Report
Budget Category Totals
Direct Services
Housing/Capital Outlays/SUD (excluded)
Other (excluded)

3. The costs associated with Capital Outlay (budget category), Housing Services (service area) and Low Barrier Substance Use Disorder Treatment (service area) are excluded from DSHP eligibility.
    a. The state assumes all Housing Services and Low Barrier Substance Use Disorder Treatment (service areas) expenditures include unallowable DSHP expenditures. Therefore, these entire service areas are excluded.
    b. Some expenditures have been allocated across both budget categories and service areas and will have to be excluded. If the sum of Capital Outlay, Housing Services, and Low Barrier Substance Use Disorder Treatment is greater than the total expenditures for the BHRNs partner that quarter, the entire partner's expenditures are excluded from DSHP claiming during the reported quarter.

4. Expenditures which are DSHP ineligible per STC #8.2 of Waiver 11-W-00415/10 and expenditures where the use of state grant funds cannot be determined by the reporting, are excluded from DSHP eligibility.
    a. As part of the BHRN report, BHRNs are required to submit a qualitative narrative that describes how funding was spent in each budget category and service area. Each narrative is reviewed to exclude unallowable expenditures.
    b. Unless the exact prohibited expenditure amount can be identified through the BHRN report narrative, the entire budget category or service area for which the expenditure is reported under is excluded.
    c. BHRN partners who provide services to individuals in jail or correctional facilities are excluded entirely from DSHP claiming because the associated costs cannot be separated.
5. An additional 2% of expenditures is removed from the Direct Services total to account for services delivered to individuals who do not meet citizenship or immigration status requirements.
    a. Administrative costs may be reported in the Services and Supplies budget category. Since Services and Supplies can include administrative costs for supplies, if those costs cannot be specifically identified, the expenditures will be considered a direct service and 2% is taken off the entire Services and Supplies expenditure.
6. After these exclusions are deducted from the total expenditure amount, the DSHP eligible amount remains.

Program: OHA, Public Health, Public Health Modernization

Specific to program processes steps: For service level expenditure reporting that is not available directly though Oregon's SFMA, expenditures are obtained through analysis of reports submitted to the State by grantees. This requires a manual collection and analysis of the combination of these reports.

1. Reports are received from counties, tribal entities, and community-based organizations quarterly and annually. Quarterly reports are broken down by month and annual reports are higher level summaries. Quarterly reports are more detailed and are used for DSHP expenditure data.
    b. These reports contain expenditure data categorized into the following *budget categories (categories vary among the report types)*:
        i. Salary and Fringe
        ii. Professional Services/Contracts
        iii. Personnel Services (Salaries and Benefits)
        iv. Travel
        v. Travel and Training
        vi. Services and Supplies
        vii. General Supplies
        viii. Medical Supplies
        ix. Equipment (not capital)
        x. Capital Purchases and Equipment
        xi. Capital Outlay
        xii. Other

2. The expenditure data is manually compiled into the categories shown in the table below.

Consolidated Expenditures Report
Total Reimbursable Expenditures
Direct Services
Capital Outlays (excluded)
Other (excluded)

3. For Staffing and Admin/Indirect expenditures, OIS uses a work charge code that identifies a specific PCA code for this body of work. Through a monthly process completed by the Cost Allocation team, the expenditure is moved to the Public Health Modernization project budget associated with the PCA (number) which is funded with general fund grant (number).
4. Expenditures which are DSHP ineligible per STC #8.2 of Waiver 11-W-00415/10 and expenditures where the use of state grant funds cannot be determined by the reporting, are excluded from DSHP eligibility.
5. An additional 2% of expenditures is removed from the Direct Services total to account for services delivered to individuals who do not meet citizenship or immigration status requirements.
6. After these exclusions are deducted from the total expenditure amount, the DSHP eligible amount remains.

Program: OHA, Non-Medicaid MH - SE06, Choice Model Services

Specific to program processes: For service level expenditure reporting that is not available directly though Oregon's SFMA, expenditures are obtained through analysis of reports submitted to the State by providers. This requires a manual collection and analysis of the combination of these reports.

1. Reports are received from providers quarterly. These reports are used for DSHP expenditure data.
    a. These reports contain expenditure data categorized into the following *budget categories:*
        i. Personnel Services (Salaries and Benefits)
        ii. Professional Services/Contracts
        iii. Travel and Training
        iv. General Supplies
        v. Medical Supplies
        vi. Capital Outlay
        vii. Indirect Costs
        viii. Other
2. The expenditure data is manually compiled into categories shown in the table below.

Consolidated Expenditures Report
Direct Services
Other Qualifying Expenditures
Housing (excluded)

3. Expenditures which are DSHP ineligible per STC #8.2 of Waiver 11-W-00415/10 and expenditures where the use of state grant funds cannot be determined by the reporting, are excluded from DSHP eligibility.
4. An additional 2% of expenditures is removed from the Direct Services total to account for services delivered to individuals who do not meet citizenship or immigration status requirements.
5. After these exclusions are deducted from the total expenditure amount, the DSHP eligible amount remains.

ATTACHMENT H
DSHP Sustainability Plan

(reserved)

ATTACHMENT J
(Protocols for HRSN Infrastructure and HRSN Services)

HRSN Infrastructure Protocol

HRSN Infrastructure. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 9.6.a. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to $119M on infrastructure investments necessary to support the development and implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline.

HRSN Infrastructure

I. Implementation Timeline and Approach

a. **Timeline for Disbursement of Infrastructure Funding**

i. The state intends to begin awarding infrastructure funds to eligible entities no sooner than July 1, 2023. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity.

ii. Eligible entities can apply for capacity building funding on an ongoing basis.

b. **Approach to Infrastructure Funding Applications and Disbursements**

i. The state will conduct the HRSN infrastructure application and funding disbursement activities through a combination of entities:

1. The state intends to perform many of the activities through contracts with Coordinated Care Organizations (CCOs) to perform the functions listed in Section I.b.ii.
2. The state intends to work with Tribal Governments to develop a tailored approach to HRSN infrastructure funding disbursement for Tribal providers and organizations.
3. The state reserves the right to assume any of the below activities directly or through a contracted vendor based on experience operationalizing the HRSN Infrastructure program.

ii. The state intends to work with CCOs to conduct the following activities:

1. Develop the infrastructure funding application and budget template
2. Conduct outreach and education to eligible entities regarding infrastructure funding opportunities
3. Review applications against minimum entity eligibility criteria

4. Review funding request budget templates to ensure compliance with requirements
5. Award infrastructure funding to eligible entities
6. Disburse funding to awarded entities
7. Monitor infrastructure funding uses amongst eligible entities to prevent fraud, waste and abuse
8. Develop reporting templates for awardees to report on funding uses
9. Review and analyze reports from awardees on funding uses

iii. CCOs will leverage a state-defined process to evaluate and approve applications and funding requests from eligible entities. The process will encompass several activities, including, for example:
1. The state will set specific HRSN application windows in which entities can apply for and receive HRSN infrastructure funding.
2. The state will collaborate with CCOs and Tribal Governments, at a minimum, to develop a process for evaluating and approving HRSN infrastructure funding requests.
3. CCOs will leverage standardized criteria to support evaluation of HRSN funding applications and requests across the following categories:
a. The entity has submitted a complete application and budget request.
b. The entity has requested HRSN funding within one of the allowable use categories listed in Section III, below.
c. The entity has provided a strong justification for the need for HRSN infrastructure funding.
d. Applicant has demonstrated ability to provide or support the provision of one or more HRSN services.

c. **Monitoring and Oversight**

i. The state, will ensure that any HRSN infrastructure fund disbursements are consistent with these STCs. The state will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:
1. **Participating in audit processes.** The state will conduct spot audits to ensure that infrastructure funds are being spent on permissible uses and are being documented and reported on appropriately.
2. **Taking action to address non-compliance.** The state will ensure that action is taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective actions (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will provide notice to any funding recipient prior to initiating corrective action.

3. **Ensuring non-duplication of funds.** Funding recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state will monitor for funding irregularities and potential duplication of funds.
4. **Monitoring for fraud, waste and abuse.** The state or will actively monitor all HRSN infrastructure disbursements for instances of fraud, waste and abuse. The state will suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste and/or abuse. The state reserves the right to recoup funding as necessary.

II. Eligible Entities. The following entities may be eligible to apply for and receive HRSN infrastructure funding:

a. Coordinated Care Organizations (CCOs)
b. Providers of HRSN services, including, but not limited to:
    i. Tribal government and tribal providers
    ii. Community-based organizations (CBOs)
    iii. Social-services agencies
    iv. Housing agencies and providers
    v. Food and nutrition service providers
    vi. Case management providers
    vii. Traditional health workers
    viii. Child welfare providers
    ix. City, county, and local governmental agencies
    x. Outreach and engagement providers
    xi. Providers of climate devices and services
c. Network Manager(s) to support, for example, HRSN contracting, implementation, invoicing and service delivery

In addition, entities must meet the following minimum eligibility criteria in order to be considered eligible for the HRSN infrastructure funding. Minimum eligibility criteria may include:

a. The entity is capable of providing or supporting the provision of one or more HRSN services to Medicaid beneficiaries within the state of Oregon.
b. The entity intends to contract to serve as an HRSN provider for at least one HRSN service.
c. The entity has attested to being financially stable, as defined by the state

III. Intended Purpose and Proposed Uses of HRSN Infrastructure Funding. The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.

a. Technology
b. Development of business or operational practices
c. Workforce development
d. Outreach, education and stakeholder convening

The State intends to provide infrastructure funding to eligible entities for the following activities:

a. **Technology.** Qualifying entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities.
    i. Procuring IT infrastructure/data platforms/systems needed to enable, for example:
        1. Authorization of HRSN services
        2. Documentation of eligibility for HRSN services and track enrollment
        3. Closed loop referral to HRSN services
        4. Record plans of care
        5. HRSN service delivery
        6. HRSN service billing
        7. HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure members receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program)
        8. Determine eligibility for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants and Children (WIC)
    ii. Modifying existing systems (e.g., community information exchange) to support HRSN
    iii. Development of an HRSN eligibility/services screening tool
    iv. Integration of data platforms/systems/tools
    v. Onboarding to new, modified or existing systems
    vi. Training for use of new, modified or existing systems

b. **Development of business or operational practices**
    i. Development of polices/procedures related to:
        1. HRSN referral and service delivery workflows
        2. Billing/invoicing
        3. Data sharing/reporting
        4. Program oversight/monitoring
        5. Evaluation
        6. Privacy and confidentiality
    ii. Training/technical assistance on HRSN program and roles/responsibilities
    iii. Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity (e.g., purchasing of a commercial refrigerator to expand capacity to provide additional medically-tailored meals to qualifying members)

iv. Procurement of administrative supports to assist implementation of HRSN

c. **Workforce development**
   i. Cost of recruiting, hiring and training new staff to provide HRSN
   ii. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing and/or executing HRSN responsibilities, time limited to a period of 18 months.
   iii. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally competent and/or trauma informed care)
   iv. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery
   v. Production costs for training materials and/or experts as it pertains to the HRSN program

d. **Outreach, education and stakeholder convening**
   i. Production of materials necessary for marketing, outreach, training and/or education related to HRSN.
   ii. Translation of materials
   iii. Planning for and facilitation of community-based outreach events to support awareness of HRSN services
   iv. Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN
   v. Community engagement activities necessary to support HRSN program implementation and launch (e.g., roundtable to solicit feedback on guidance documents)
   vi. Administrative or overhead costs associated with outreach, education or convening directly tied to HRSN.

IV. **Projected Expenditure Amounts:** The state estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. The state used the annual infrastructure spending amounts articulated in the state's STCs, and an analysis of anticipated need across the state to develop the estimates below. The state anticipates that the percentage of spend permissible use categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years.

The state will notify CMS annually of any significant change to percentage spend, defined as greater than a fifteen (15) percentage point difference, across any of the allowable use categories below.

Allowable Use Category	% of Spend	Estimated Amount
Technology	30%	$35.7M
Development of Operational or Business Practices	25%	$29.75M
Workforce Development	30%	$35.7M

Outreach, Education and Stakeholder Convening	15%	$17.85M
Total	**100%**	**$119M**

HRSN Services Protocol

HRSN Services. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs) this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) program, as specifically required by STC 9.6(b). The state may claim FFP for the specified evidence based HRSN services identified in STC 9.2, (subject to the restrictions described below and the exclusions in STC 9.4). This protocol outlines the covered HRSN services, a process for identifying eligible individuals, a process for determining the services medically appropriate, and a description of the process for developing care plans based on assessment of need.

I. Member Eligibility.

a. Covered Populations. The following covered populations will be eligible to receive HRSN services provided that they also satisfy the applicable clinical and social risk criteria and the HRSN service is determined to be medically appropriate:

Covered Population	Population Description
Young Adults with Special Health Care Needs (YSCHN)	Including: • Members aged 19 to 26, with income up to 300% of the Federal Poverty Level (FPL), meeting at least one of the following criteria: • One or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PMCA); • Serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; • Diagnosed intellectual or developmental disability; • "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; and • Starting no earlier than January 1, 2026, two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions.

Adults and youth discharged from an Institution for Mental Disease (IMD), residential mental health and substance use disorder facility, or inpatient psychiatric unit	Including members who were discharged from an IMD, residential mental health and substance use disorder facility, or inpatient psychiatric unit in the last 12 months. Eligibility must be determined within 12 months of discharge.
Adults and youths released from incarceration	Including members released from incarceration within the past 12 months, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections, and tribal correctional facilities. Eligibility must be determined within 12 months of discharge.
Youth involved with child welfare	Including members who are currently or have previously been: • In foster/substitute care; • Receiving adoption or guardianship assistance or family preservation services; or • The subject of an open child welfare case in any court.
Individuals transitioning to Dual Status	Members enrolled in Medicaid that are transitioning to dual Medicaid/Medicare status. Members shall be included in this covered population for the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 9 months after it takes effect. Eligibility must be determined within 9 months of transition.
Individuals who are homeless or at risk of homeless	Members who meet the definition of homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.

b. Medical Appropriateness. To ensure the services are medically appropriate, the state will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for a HRSN service, a member must:

i. Meet the eligibility criteria for one or more of the covered populations (described above in Section I.a);

ii. Have at least one of the clinical risk factors. The Climate Device-specific clinical risk factors and associated Outreach and Engagement

services are listed in the appendix in Table 1. The HRSN clinical risk factors for housing, nutrition, and outreach and engagement broadly are listed in the appendix in a second Table 2.;

iii. Have one of the following social risk factors; and

iv. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service (e.g., utility costs may only be provided for members who are also receiving rent/temporary housing).

c. **Clinical Risk Factors.** In order to receive a Climate Device or Outreach and Engagement services at launch, individuals must meet one of the climate device specific clinical risk factors listed in the appendix. To receive a Housing, Nutrition, or Outreach and Engagement services, individuals must meet one of the HRSN clinical risk factors listed in the appendix based on assessment and included in the individuals plan of care.

Social Risk Factor	Risk Factor Description
Housing Related Need	• An individual who: Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; or ○ Requires a clinically appropriate home modification/remediation service.
Nutrition-Related Needs	• An individual meeting the USDA definition[9] of low food security.
HRSN Device Needs	• An individual who resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, portable power supply (PPSs), and/or refrigeration units for medications is Clinically Appropriate as a component of health services treatment or prevention.

[9] *Definitions of Food Security* (2022). USDA Economic Research Service. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-foodhttps://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-securitysecurity

d. **Publicly Maintained Criteria.** The state will maintain the clinical and social risk criteria detailed above on a public facing OHA webpage, and require that CCOs and FFS TPCs also maintain these criteria on a public facing webpage. The content will be updated if the criteria is changed. Any changes must be approved by CMS prior to posting.

II. HRSN Services

a. **Use of a Third-Party Contractor or Other Contracted Vendor.** OHA may contract with a third-party contractor (TPC) or other entity to perform service approval, care management, and other functions related to the administration of HRSN services for members covered under the FFS program (hereafter referred to as "FFS TPC"). The state will work with Tribal Government on a culturally responsive and specific HRSN service delivery approach for American Indian/Alaska Native (AI/AN) members.

b. **Providing culturally and linguistically appropriate services.** All HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services. The state will require CCOs, and the FFS TPC to provide services in support of OHA's health equity goals, consistent with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) to ensure language access across all services.

c. **Nonduplication of services.** No HRSN service will be covered that is found to be duplicative of a state or federally funded service or other HRSN service the member is already receiving.

d. **Covered HRSN Services.** The state will cover the following HRSN services as defined below:

Service	Description
Rent/temporary housing	Payment for rent and/or short-term, temporary stays for up to six months, including: 1. Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes; manufactured home lots, motel or hotel when it is serving as the member's primary residence, transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may

	or may not offer supportive services and programming. Eligible costs include: • Rent payment (past due or forward rent) • Storage fees • Renter's insurance if required by the lease • Landlord paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments Payments must only be provided in connection with dwellings that meet maintenance regulation code within the local jurisdiction for safety, sanitation, and habitability. Rent/temporary housing is only available to individuals who are transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), residential mental health and substance use disorder facilities, or inpatient psychiatric units, correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.
Utility costs	Utility costs are limited to households receiving rent assistance/temporary housing and are available for up to six months. This service provides payment for: 1. Recurring utilities 2. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills This service will cover expenses for the following types of utility payments: ○ Garbage ○ Water ○ Sewage ○ Recycling ○ Gas ○ Electric ○ Internet

	○ Phone (inclusive of land line phone service and cell phone service)
Pre-tenancy and housing transition navigation services	Pre-tenancy and housing navigation services are supports to individuals or households, or both individuals and households, to achieve their stability goals, as defined by them. These case management/coordination services include: 1. Working with the individual to develop a housing plan that supports the stated needs of the member and/or household to achieve their stability goals; 2. Reviewing, updating, and modifying the plan with the member to reflect current needs and preferences and address existing or recurring housing retention barriers; 3. Searching for housing and presenting options; 4. As needed, facilitating enrollment in the local Continuum of Care's Coordinated Entry System; 5. Assisting in completing housing applications and payment of any housing application or inspection fees;

	6. Assisting in coordinating transportation to ensure access to housing options prior to transition and on move in day; 7. Ensuring that the living environment is safe and ready for move-in; 8. Assisting in arranging for and supporting the details of the move; 9. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 10. Assist the member in communicating with the landlord and property manager; 11. Providing training and resources to assist the member in complying with the member's lease; 12. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 13. Providing supports to assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation, etc.); 14. Supporting housing stability by facilitation of the enrollment of individuals of the household in local school and college systems; or 15. Coordinating referrals for access to other necessary medical, disability, social, educational, legal, income-related tools and resources for housing, and other services.
Tenancy Sustaining Services	Services to assist individuals in maintaining housing stability. This assistance may include: 1. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 2. Providing supports to assist the member in communicating with the landlord and property manager;

	3. Providing training and connections to resources to assist the member in complying with the member's lease; 4. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 5. Assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, maintain relationships with neighbors or roommates, reduce social isolation, utilize local transportation, connect to needed behavioral health or other healthcare services, peer mentors or social supports, etc.); 6. Supporting housing stability by coordinating to facilitate the enrollment of individuals of the household in local school and college systems; or 7. Coordinating referrals for other necessary medical, social, educational, legal, and other services (e.g., connections to behavioral health treatment providers).
One-time transition and moving costs and housing deposits	One-time transition and moving costs necessary to establish a basic household such as: 1. Deposits needed to secure housing (i.e. security deposits); and first months and last month's rent as required by landlord for occupancy; 2. Utility set-up fees/deposits and up to six months of unresolved utility arrearages if necessary to set up services in new residence; and first month coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet and phone (inclusive of land line phone service and cell phone service); 3. Relocation expenses; 4. Pantry stocking at move in; or Basic household goods and furniture, which may include appliances necessary for food consumption, bedding, furnishings, cribs, bathroom supplies, and cleaning supplies

Medically necessary home accessibility modifications and remediation services	The provision of medically necessary home accessibility modifications and remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. • Accessibility modifications may include: ramps, hand rails, pathways, grip bars, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces, sound proofing, overhead track systems, among other modifications necessary for access, health, and safety, subject to OHA approval. • Home remediation services may include: chore services (inclusive of heavy housecleaning, removal of hazardous debris or dirt, and removal of yard hazards), pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens.
Nutrition Education	Any combination of educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being. s service may consist of the following: 1. Provision of nutrition education or information to an individual or group that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources. 2. Meal preparation education in an individual or group setting. Nutrition education services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being. s service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate. •

Assessment for Medically Tailored Meals	Initial assessment with a Registered Dietitian Nutritionist (RDN) (preferred), or, if not available, a primary care provider, to develop a medically appropriate nutrition care plan for the HRSN "Medically Tailored Meals" service. This service also covers a reassessment, if needed, to understand whether the delivery of a service is meeting the member's needs.
Medically Tailored Meals	Meals tailored to support individuals with health-related condition(s) for which nutrition supports would improve health outcomes. This service includes: 1. The preparation and provision of the prescribed meals consistent with the nutrition care plan, up to 3 meals a day, for up to 6 months; and 2. Delivery of the meal. Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a member's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food. If a member is receiving 3 medically tailored meals/day, the member may not concurrently receive can't receive pantry stocking, meals, or and food prescriptions simultaneously. The service must: • Be provided in accordance with nutrition-related national guidelines, such as the Dietary Guidelines for Americans, or evidence-based practice guidelines for specific chronic diseases and conditions. • Follow food safety standards. • Consider an individual's personal and cultural dietary preferences.
Meals	Receipt of prepared hot foods, meal kits or restaurant meals to supplement HRSN "Pantry Stocking" for members who require additional food supports, in particular for but not limited to supporting members' engagement with healthcare or other supportive services. This service may

	also be provided in place of HRSN "Pantry Stocking" for members who do not have the means to prepare or store groceries (e.g., individuals who are unhoused). Member may pick up food from food retailer or have food delivered to the Member's home or private residence, if delivery service is available. This service must be consistent with the nutrition care plan and is available for up to 3 meals a day, for up to 6 months.[10] This service may: • Take into account a member's household size • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Pantry Stocking	This service allows a Member to purchase an assortment of foods aimed at promoting improved nutrition for the member. Member may pick up food from food retailer or have food delivered to the Member's home or private residence, if delivery service is available. This service must be consistent with the nutrition care plan and is available for up to 3 meals a day, for up to 6 months.[2] Examples of allowable foods include: • Fruits and vegetables; • Meat, poultry, and fish; • Dairy products; • Breads and cereals; • Snack foods and non-alcoholic beverages; and

[10] This intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria

	• Seeds and plants, which produce food for the household to eat. This service may: • Take into account a member's household size • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

Fruit and Vegetable Prescriptions	This service allows a Member to purchase fruits and vegetables from participating food retailers and farms. Fruits and vegetables available for purchase through this service may be fresh, frozen, or canned. Member may pick up food from food retailer or have food delivered to where the Member resides, if delivery service is available. This service is limited to 6 months and must be tailored to health risk, certain nutrition-sensitive health conditions., and/or demonstrated outcome improvement. This service may: • Take into account a member's household size for children, YSHCN, and pregnant individuals using the SNAP definition of a household to determine the benefit level for these beneficiaries. Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines.

	• Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Medically necessary air conditioners, heaters, air filtration devices, portable power supplies, and refrigeration units	The provision, service delivery, and installation as needed of one or more of the following "home devices" (i.e., air conditioners, heaters, air filtration devices, portable power supplies and refrigeration units) to individuals for whom such equipment is Clinically Appropriate and medically necessary as a component of health services treatment or prevention for a climate-device specific medical indication (see details in Appendix). Examples include the following: 1. Air conditioners for individuals at health risk due to significant heat; 2. Heaters for individuals at increased health risk due to significant cold; 3. Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed; 4. Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs (e.g., because it has inadequate temperature controls to meet their medication storage needs, etc.); or, 5. Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.

HRSN Outreach and Engagement, and Other Benefit Linkages	Activities may include: 1. Attempting to contact and engage individuals who belong to one or more HRSN Covered Populations and who may be eligible for HRSN services; 2. Using multiple strategies for engagement, including in person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; Using multiple strategies for engagement, including in-person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; 3. Documenting outreach and engagement attempts, outcomes, and modalities; 4. Working with the member to provide the information necessary for assessment of HRSN service need, including through multiple engagements with the member as needed; 5. Determining whether the member is enrolled in the Fee for Service (FFS) program or a Coordinated Care Organization (CCO), and if a CCO which one, and then
	transmitting the partially or fully completed HRSN Request Template (described below) to the member's CCO or to the FFS program (or its designated third-party contractor) for eligibility determination and service authorization; 6. Helping the member to enroll, re-enroll, or maintain enrollment in Medicaid; 7. Providing help with securing and maintaining entitlements and benefits, such as TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits, and other federal and state housing programs; 8. Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) needed to receive benefits and other supports; 9. Connecting individuals to settings where basic needs can be met, such as access to shower, laundry, shelter, and food; or 10. Providing members who may have a need for medical, peer, social, educational, legal, and other related services with information and logistical support

	necessary to connect them with the needed resources and services. 11. Providing application assistance and coverage of state and federal benefit programs' application fees as required for the services and activities listed above.

III. **Provider Qualifications**

a. Service providers will be required to meet the following minimum qualification requirements:

i. Demonstrate the capacity and experience to provide HRSN services as described below:

1. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.
2. Nutrition services providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.
3. HRSN outreach and engagement and benefit linkages providers must have knowledge of principles, methods, and procedures of these services or comparable services meant to outreach to and engage the populations covered under the waiver and connect them to benefits and services to meet their needs.
4. Providers of medically necessary home devices during significant weather events (e.g., ACs during heat waves) must have knowledge and experience in providing such devices during significant weather events, including the ability to store devices and distribute them prior to or during the event so that members have access to the devices when they need them most (i.e., while the event is taking place)
5. Providers of medically necessary devices at times other than during significant weather events must have the ability to timely and appropriately deliver devices to members' homes.
6. **HRSN Provider Experience and Expertise**: All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality services to qualifying members as well as have culturally specific expertise to connect

with members of priority populations. Qualifications may include, for example:

a. Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.
b. Demonstrate their capabilities and/or experience with effectively serving at least one "priority population," as determined by the state. HRSN Providers may demonstrate these capabilities and/or experience through, for example:
    1 Providing letter(s) of support from community members being served or other entities in the community, describing the HRSN Provider's presence in the community and impact on individual community members and/or the community as a whole.
    2 Submitting an annual report or similar document that describes the HRSN Provider's relevant capabilities and activities
    3 Other methods deemed appropriate by the CCO or FFS TPC.
    4 Demonstrate that it has qualified service delivery and administrative staff, as determined at CCO or FFS TPC discretion.
c. The ability to comply with applicable federal and state laws.
d. The capacity to provide culturally and linguistically appropriate, responsive and trauma-informed service delivery, including by ensuring their ability to:
    1 Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to Members with diverse cultural and ethnic backgrounds
    2 Meet cultural needs of the community for whom it provides services
    3 Provide documentation of how cultural responsiveness and trauma informed care trainings are impacting organizational policies and staff practices
    4 Document efforts to recruit and employ staff who reflect the HRSN Provider's region's Medicaid population, including individuals with similar

demographics, lived experience, background and language fluency to the greatest extent possible.

e. A history of responsible financial stewardship and integrity via a CCO-conducted audit and/or recent annual financial reports.

b. CCOs and the FFS program will be required to ensure that HRSN service providers meet and maintain compliance with these minimum qualification requirements.

IV. Member Identification and Assessment of Service Need.

a. Member Identification. The state will ensure individuals can be identified for HRSN services through many different pathways.

i CCOs and the FFS TPC will ensure multiple pathways for individuals to be identified as being enrolled in Medicaid, belonging to an HRSN Covered Population, and potentially having one or more HRSN Service needs. Pathways for Member identification must include:

1. CCOs/FFS TPC proactively identifying Members through a review of Contractor's encounter and claims data;
2. Contracting with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify Members and make HRSN Recommendations (described further below);
3. Engaging with and receiving HRSN Recommendations from organizations other than HRSN Service Providers (called "HRSN Connectors"); and
4. Accepting Members' self-referral.

ii. The following are examples of individuals and entities that may serve as HRSN Connectors and will have a pathway to identify individuals in need of HRSN services:

1. CCO and FFS TPC
2. Private and public housing service agencies and housing providers
3. Nutrition service agencies and providers
4. Correctional institutions
5. Health care providers including but not limited to primary care providers, behavioral health providers, hospitals, and long-term services and supports (LTSS) providers
6. State, local, and federal agencies who engage with Medicaid members
7. Traditional health workers
8. Child welfare workers and other case managers
9. Other CBOs who engage with Medicaid members

10. Individuals will also be permitted to self-refer for HRSN services

ii. The state will require CCOs or any TPCs used for the FFS program to conduct outreach and seek to engage in HRSN services specific populations or specific individuals identified by the state as a high priority. In addition, the state will require CCOs or any TPCs used for the FFS, to proactively identify members who may be eligible for HRSN services or who may be the priority populations for HRSN services, as established by the state and in accordance with state -established guidelines.

iii. CCOs and, if applicable the FFS TPC, will be required to estimate the number of individuals they expect to serve each year with HRSN services, as well as report to the State on the actual number of individuals they do serve.

b. HRSN Requests.

i. The state will provide an HRSN Request Template that contains necessary information about individuals identified with a service need for an approval decision. HRSN Connectors that recommend individuals to receive HRSN services may use the State-developed HRSN Request Template or another tool of their choosing, so long as it captures the following information:

1. The name and contact information for the individual being recommended for HRSN services
2. Identification of one or more HRSN Service needs the individual may need

ii. Other information that may be documented in the HRSN Request includes confirmation of OHP Medicaid enrollment and confirmation of enrollment a particular CCO/FFS Medicaid as well as any other information regarding the individuals potential HRSN eligibility. All HRSN Recommendations must include a statement that the recommended individual desires to take part in further HRSN eligibility determination process.

iii. An entity (called "HRSN Connectors") that identifies a member in need of HRSN services will work with the member or their guardian to complete the information in the HRSN Request Template and transmit it to the member's CCO or the FFS TPC. If the entity does not know whether the member is enrolled in the FFS program or a CCO, or which CCO the member is enrolled in, the entity may follow its preferred approach to connecting the member with appropriate resources, which may include calling the local CCO or CCOs, calling OHA member services, or seeing if there is relevant information in the Homeless Management Information System (HMIS).

iv. The transmission of the information in the HRSN Request Template to a CCO or the FFS TPC can occur through a variety of delivery methods including, but not limited to email, fax, mail personal delivery or any other reasonable delivery method. These pathways must be made clear and accessible to members, CBOs, providers, and other potential entry points through information posted on the websites of each CCOs and FFS TPC and through other means.

v. HRSN Connectors may submit to a CCO or the FFS TPC a partially completed HRSN Request Template. It will be the responsibility of the CCO or FFS TPC to follow up with the member and, if needed and appropriate, the entity that submitted the form, to obtain the additional information needed to determine eligibility and authorize services. The CCO or FFS TPC will be required to document its attempts to collect the information needed to determine eligibility.

V. Eligibility Determination and Services Approval

a. Upon receipt of the information regarding the individual's HRSN needs, the CCO, Tribal Government, or the FFS TPC will use reasonable efforts to obtain all other information necessary to 1) determine whether the individual is eligible for HRSN and 2) to authorize the appropriate services. The CCO/FFS TPC reasonable efforts must include:
    a. using the information included in CCO's/FFS TPC's own records,
    b. obtaining only the relevant information from the Member, and when permitted by the Member,
    c. obtaining the relevant and appropriate information from the HRSN Connector.

a. If, after completing the HRSN eligibility determination and documenting all the required information in, the Member meets all of the criteria for being HRSN eligible, the CCO/FFS TPC must authorize the identified HRSN Services need as expeditiously as possible. The service approval will be based on the following criteria:
    i. Confirmation that the member is enrolled in the Oregon Health Plan;
    ii. Determination that the individual meets the eligibility criteria for one of the
    HRSN covered population groups;
    iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
    iv. Assessment of the individual's clinical and social needs (described above in
    Section I.b) that justify the medical appropriateness of the service; and,
    v. Determination of the medically appropriate service duration, not to exceed twelve months for an initial authorization.

b. CCOs and the FFS TPC will be required to:

i. Notify the individual of approval or denial of the service and provide information about appeals and hearing rights.
    i CCOs and the FFS TPC shall notify all individuals who have undergone an HRSN Service authorization or denial as expeditiously as the circumstances require, not to exceed fourteen (14) calendar days from the date of, as applicable and appropriate, authorization or denial. CCOs and FFS TPC will follow individual preferences for method of communication (e.g., e-mail, phone call, etc.).
    ii Individuals who are denied HRSN Services or are authorized for HRSN Services but such authorization is limited in scope, amount, or duration, have Grievance and Appeal rights.
ii. Document the approval or denial of services through the closed loop referral technology; or chosen alternative system by the referring entity, ensuring a closed loop of the referral.

VI. Care Management and Service Plans

a. The CCOs/FFS TPC will conduct care management for individuals approved for HRSN services. The care management will include:
    i. Developing the person-centered service plan (PCSP) with the member, with review at least every 12 months;
    ii. Referring the member to a HRSN provider for the approved services, and supporting member choice of provider, ensuring member needs are met by the
    Provider, including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed;
    iii. Identifying other HRSN services the member may need;
    iv. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
    v. Coordinating with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service;
    vi. Conducting reassessment for services prior to the conclusion of the service; and
    vii. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.

b. The CCO/FFS TPC care manager and the member will create the PCSP for the individual to obtain the HRSN service as approved by the CCO/FFS TPC. The PCSP will be in writing and developed with and agreed upon by the member.

i. The PCSP will include:
    1. The recommended HRSN service;
    2. The service duration;
    3. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
    4. The goals of the service(s);
    5. The follow-up and transition plan;
    6. The CCO/FFS TPC care management team responsible for managing the member's HRSN services.

c. The care manager is required to have one meeting with the individual, either in person or by telephone or videoconference during the development of the PCSP. If efforts to have a meeting are unsuccessful, the care manager is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

d. The PCSP must be contained within the same document as the individual's Care Plan, outlined in Oregon Administrative Rule.

e. A parent, guardian, or caregiver of a member may receive an HRSN service on the member's behalf if the parent, guardian, or caregiver lives with the member and it is in the best interest of the member as determined through the PSCP.

VII. Conflict of Interest

a. To protect against conflict of interest and ensure compliance with HCBS conflict of interest standards, the state will require that the CCO and FFS TPC perform the service authorization function and develop the PCSP and prohibit the subcontracting of such functions where that would result in a single entity conducting the assessment, service planning, and service provision, except as provided in subsection (b) and (c) below, or otherwise approved by OHA.

b. Assessment, service planning, and service provision for select services may be provided by: (i) CCOs and (ii) the FFS TPC, subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflicts of interest in accordance with all applicable requirements.

c. If the state contracts with Tribal organizations to perform HRSN service authorization and service planning for American Indian/Alaskan Native (AI/AN) enrolled in the state's FFS program, those Tribal organizations may also furnish HRSN services, subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflict of interest in accordance with all applicable requirements.

VIII. Payment

a. After providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN service providers will submit an invoice and additional required documentation to the member's CCO or the FFS TPC.

b. CCOs and the FFS TPC will reimburse HRSN service providers according to a fee schedule for HRSN services to be developed by the state, as detailed in the New Initiatives Implementation Plan.

c. CCOs and the FFS TPC may also pay HRSN services providers in advance for select services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.

Appendix: Climate Device Specific, Housing/Nutrition, and Related Outreach and Engagement Clinical Risk Factor Criteria

Guidance: In consideration of prioritization for outreach, health plans should consider priority populations, members with unstable or severe symptoms, members with more than one of these conditions, and individuals at the extremes of age. In addition, health plans should consider other medical conditions for review by exception including hyperthyroidism, autoimmune conditions, immunosuppression, fluid/electrolyte/acid base conditions, use of medication that impacts thermoregulation, etc.

In addition, health plans will utilize different outreach methods depending on the population they are contacting, ranging from low intensity outreach (e.g., general information across MyChart) to high intensity outreach (e.g., text messages, phone calls, etc.).

Table 1. Climate Device-Specific and Related Outreach and Engagement Clinical Risk Factors (Condition must have been active in the past 12 months. Members must meet age or pregnancy criteria at the time of eligibility determination, as relevant.)	**Eligible Climate Device**
Schizophrenia spectrum and other psychotic disorders	Air Conditioner, Air Filtration Device, Heater
Bipolar and related disorders	
Major depressive disorder with an acute care need in the past 12 months including a suicide attempt, crisis services utilization (emergency department, mobile crisis team, etc.), acute psychiatric hospitalization, or residential treatment.	
One or more of the following substance use disorders: alcohol use disorder, hallucinogen use disorders, inhalant use disorder, opioid use disorder, stimulant use disorder	
Major neurocognitive disorders	
Chronic lower respiratory condition including chronic obstructive pulmonary disease (COPD), asthma requiring regular use of asthma controlling medications, restrictive lung disease, fibrosis, chronic bronchitis, bronchiectasis	
Chronic cardiovascular disease, including cerebrovascular disease and heart disease	
Spinal cord injury	
In-home hospice	
Any sensory, physical, intellectual, or developmental disability that increases health risks during extreme climate events	
Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • Malnutrition • Dehydration	

• Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) • Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn#i) • An acute or chronic respiratory condition • A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness • Low birth weight of <2500 grams	
Pregnant and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • An acute or chronic respiratory condition • Infection • High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) • History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth • Abuse or interpersonal violence • Malnutrition • Hyperemesis gravidarum and other causes of dehydration • Maternal low birth weight of <2500 grams • Multiple pregnancy • Mental health condition	
Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • Malnutrition • Dehydration • Currently taking medications that impact heat tolerance, including for upper respiratory infections, allergies, COPD, muscle spasms, blood pressure, diuresis, diarrhea, constipation, anti-inflammation, mental health conditions, and sleep • Abuse or neglect • A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness • Mental health condition • Two or more chronic health conditions	
Chronic kidney disease	Air Conditioner,

Diabetes mellitus, requiring any medication, oral or insulin	Heater
Multiple sclerosis	
Parkinson's disease	
Previous heat-related or cold-related illness requiring urgent or acute care, e.g. emergency room and urgent care visits	
Individual requires home oxygen use: home oxygen, oxygen concentrators, home ventilator	Air Filtration Device
Individual uses medications requiring refrigeration. Examples include: • Medications for diabetes mellitus, glaucoma, and asthma; • TNF inhibitors	Mini-refrigerator
Enteral and parenteral nutrition	
Individual needs durable medical equipment (DME) requiring electricity for use. Examples include but are not limited to: • Oxygen delivery systems, including concentrators, humidifiers, nebulizers, and ventilators • Intermittent positive pressure breathing machines • Cardiac devices • In home dialysis and automated peritoneal dialysis • Feeding Pumps • IV infusions • Suction pumps • Power wheelchair and scooter • Lift systems and electric beds • Breast pumps for first 6mo post-partum • Other DME medically required for sustaining life	Portable Power Supply
Individual requires assistive technologies requiring electricity necessary for communication or ADLs.	
Other conditions approved by medical exception in an individual review for medical exception aligned with OHA's Medical Management Committee Process and CCO exception review process	Any of the above devices

Table 2. Housing, Nutrition, and Related Outreach and Engagement Clinical Risk Factors

HRSN Clinical Risk Factor	Risk Factor Description
Complex Behavioral Health Need	• An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Developmental Disability Need	• An individual with an Intellectual Disability or Developmental Disability (as defined by OAR 411-320-0080) that requires services or supports to achieve and maintain care goals.

Complex Physical Health Need	• An individual with a persistent, disabling, progressively or life-threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation. • Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression
Needs Assistance with ADLs/IADLs or Eligible for LTSS	• An individual who needs assistance with one or more Activities of Daily Living (ADLs) as defined in OAR 411-015-0006 or Instrumental Activities of Daily Living (iADLs) as defined in OAR 411-015-0007; or • Receives or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.
Interpersonal Violence Experience	• An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
Repeated Emergency Department Use and Crisis Encounters	An individual: • With repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); • With two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care.
	• Who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of a behavioral health condition, significant life stress, adversity, or trauma.

Pregnant/Postpartum	An individual who is currently pregnant or up to 12 months postpartum and currently has, has a history of, or is at risk for at least one of the following: • Infection • High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) • Pregnancy-related death • History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, hyperemesis gravidarum, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth • Abuse or interpersonal violence • Malnutrition • Maternal low birth weight of <2500 grams • Multiple pregnancy • A mental health condition or substance use disorder, including a postpartum mental health condition • Significant life stress, adversity, or trauma •
Children less than 6 years of age	A child who is less than six years of age and currently has, has a history of, or is at risk for at least one of the following: • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition • Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) • Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn#i) • Low birth weight of <2500 grams • Mental health condition • Significant life or family stress, adversity, or trauma
Adults 65 years of age or older	An adult who is 65 years of age or over and currently has, has a history of, or is at risk for at least one of the following: • Two or more chronic health conditions • Social isolation placing the individual at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse

	• Malnutrition • Dehydration • Abuse or neglect • Significant life adversity stress, adversity, or trauma
Young Adults with Special Health Care Needs	An individual aged 19 to 26, with the following clinical risk factors defined in STC 4.6(a): • Have one or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PCMA); • Have a serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; • Have a diagnosed intellectual or developmental disability; • Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or • Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions as described in the New Initiatives Implementation Plan.

Target Populations	Housing Services						
	Rent/temporary housing for up to 6 months	Utility costs	One-time transition and moving costs	Housing deposits to secure housing	Pre-tenancy and tenancy sustaining services	Housing transition navigation services	Medically necessary home accessibility modifications and remediation services
Youth with Special Health Care Needs (YSHCN) ages 19-26			X	X	X	X	X
Adults and youth discharged from an IMD, residential mental health and substance use disorder facility, or inpatient psychiatric unit	X	X	X	X	X	X	X
Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities	X	X	X	X	X	X	X
Youth involved in the child welfare system, including youth transitioning out of foster care;	X	X	X	X	X	X	X
Individuals transitioning from Medicaid-only to dual eligibility status			X	X	X	X	X
Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	X	X	X	X	X	X	X

**Meals or pantry stocking are available to individuals within the transition populations who are children under 21, YSHCN, or pregnant.*

Target Populations	Nutrition Services				Climate Supports
	Nutrition counseling and education, including on healthy meal preparation	Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months	Meals or pantry stocking*	Fruit and vegetable prescriptions, for up to 6 months	Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units
Youth with Special Health Care Needs (YSHCN) ages 19-26	X	X	X	X	X
Adults and youth discharged from an IMD, residential mental health and substance use disorder facility, or inpatient psychiatric unit	X	X	X	X	X
Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities	X	X	X	X	X
Youth involved in the child welfare system, including youth transitioning out of foster care;	X	X	X	X	X
Individuals transitioning from Medicaid-only to dual eligibility status	X	X	X	X	X
Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	X	X	X	X	X

**Meals or pantry stocking are available to individuals within the transition populations who are children under 21, YSHCN, or pregnant.*

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Rent/temporary housing for up to 6 months	Individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), residential mental health and substance use disorder facilities, inpatient psychiatric units, correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Utility costs	Limited to those receiving Rent/Temporary housing	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

One-time transition and moving costs	All HRSN Services Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Housing deposits to secure housing	All HRSN Services Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention	All HRSN Eligible Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Housing transition navigation services	All HRSN Eligible Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Medically necessary home accessibility modifications and remediation services	All HRSN Eligible Populations	An individual who requires a clinically appropriate home modification/remediation service	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Nutrition counseling and education, including on healthy meal preparation	All HRSN Eligible Populations	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months	All HRSN Eligible Populations	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Meals or pantry stocking	Children under 21, YSHCN, and pregnant individuals who are also in an HRSN - eligible population	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Fruit and vegetable prescriptions, limited to 6 months, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement	All HRSN Eligible Populations	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

[1] Definitions of Food Security (2022). USDA Economic Research Service. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-foodhttps://www.ers.usda.gov/topics/food-nutrition- assistance/food-security-in-the-u-s/definitions-of-food-securitysecurity

Clinical Risk Factor	Clinical Criteria Detail
Complex Behavioral Health Need	An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Developmental Disability Need	An individual with an Intellectual Disability or Developmental Disability (as defined by OAR 411-320-0080) that requires services or supports to achieve and maintain care goals.
Complex Physical Health Need	An individual with a persistent, disabling, progressively or life-threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation. Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression
Needs Assistance with ADLs/IADLs or Eligible for LTSS	An individual who needs assistance with one or more Activities of Daily Living (ADLs) as defined in OAR 411-015-0006 or Instrumental Activities of Daily Living (iADLs) as defined in OAR 411-015-0007; or Receives or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.
Interpersonal Violence Experience	An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence

Repeated Emergency Department Use and Crisis Encounters	An individual: - With repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); - With two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care. - Who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of a behavioral health condition, significant life stress, adversity, or trauma.

Clinical Risk Factor	Clinical Criteria Detail
Pregnant/Postpartum	An individual who is currently pregnant or up to 12 months postpartum and currently has, has a history of, or is at risk for at least one of the following: - Infection - High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) - Pregnancy-related death - History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, hyperemesis gravidarum, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth - Abuse or interpersonal violence - Malnutrition - Maternal low birth weight of <2500 grams - Multiple pregnancy - A mental health condition or substance use disorder, including a postpartum mental health condition - Significant life stress, adversity, or trauma

Children less than 6 years of age	A child who is less than six years of age and currently has, has a history of, or is at risk for at least one of the following: - Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition - Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM Surveillance-a.pdf) - Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus- areas/children-youth-special-health-care-needs-cyshcn#i) - Low birth weight of <2500 grams - Mental health condition - Significant life or family stress, adversity, or trauma
Adults 65 years of age or older	An adult who is 65 years of age or over and currently has, has a history of, or is at risk for at least one of the following: - Two or more chronic health conditions - Social isolation placing at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse - Malnutrition - Dehydration - Abuse or neglect - Significant life adversity stress, adversity, or trauma

Clinical Risk Factor	Clinical Criteria Detail
Young Adults with Special Health Care Needs	An individual aged 19 to 26, with the following clinical risk factors defined in STC 4.6(a): - Have one or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PCMA); - Have a serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; - Have a diagnosed intellectual or developmental disability; - Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or - Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions as described in the New Initiatives Implementation Plan

ATTACHMENT K
Oregon Provider Payment Rate Increase Assessment – Attestation Table

Oregon Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to provider payment rate increase requirements for the demonstration period of performance DY21 thru DY25		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	74%	91%

Methodology Description	Ratio derived under STC 10.5.b. Historical data from Oregon's MMIS database for calendar year 2021 was gathered to identify the utilization and reimbursement for primary care services based on the criteria defined by OHA. The Medicare fee schedule rates for 2021 were mapped to the summarized Medicaid data by procedure code, modifier, region, and facility status. Medicare equivalent paid amounts were determined based on the corresponding Medicaid units and Medicare fee schedule rates. Average unit costs were calculated by payer (Medicaid - FFS and Medicare) and procedure code. Further detail describing the methodology and assumptions that were relied on for the reimbursement rate analysis are documented within the '*OR Medicaid - Primary Care Rate Analysis CMS 20220915*' file.	Ratio derived under STC 10.6.b. Historical data from Oregon's MMIS database for calendar year 2021 was gathered to identify the utilization and reimbursement for primary care services based on the criteria defined by OHA. The Medicare fee schedule rates for 2021 were mapped to the summarized Medicaid data by procedure code, modifier, region, and facility status. Medicare equivalent paid amounts were determined based on the corresponding Medicaid units and Medicare fee schedule rates. Average unit costs were calculated by payer (Medicaid - CCO and Medicare) and procedure code. Further detail describing the methodology and assumptions that were relied on for the reimbursement rate analysis are documented within the '*OR Medicaid - Primary Care Rate Analysis CMS 20220915*' file.

Obstetric Care Services	112%	112%

Methodology description	Ratio derived under STC 10.5.a.i Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3)	Ratio derived under STC 10.6.a. State rules require that nonparticipating providers be paid at the state FFS rate. As a result, CCO payment rates are consistently at or above FFS rates, and the 112% metric is a reasonable and appropriate proxy for the average provider rates paid by managed care plans for this category of service
Behavioral Health Services	110%	110%
Methodology description	Ratio derived under STC 10.5.a.ii For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)	Ratio derived under STC 10.6.a. State rules require that nonparticipating providers be paid at the state FFS rate. As a result, CCO payment rates are consistently at or above FFS rates, and the 110% metric is a reasonable and appropriate proxy for the average provider rates paid by managed care plans for this category of service
In accordance with STCs 10.1 through 10.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment rate increases for each service will be effective beginning no later than October 1, 2024 and will not be lower than the highest rate for that service code in DY21 (October 1, 2022 – September 30, 2023), including any modifiers or qualifiers such as facility type, plus an		

amount necessary so that the Medicaid to Medicare ratio increases by two percentage points relative to the rate for the same or similar Medicare billing code through at least September 30, 2027.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under a managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and provider types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

~~For provider payment rates paid under a managed care delivery system, the data and methodology~~ for any one of the service categories as provided in STC 10.6.b will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b.*]

☒ a. The effective date of the rate increases is the first day of DY23 and will be at least sustained, if not higher, through DY25.

☐ b. Oregon has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing the provider payment rate increase on the first day of DY23. Oregon will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY25.

Oregon *does* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, I agree to submit by no later than December 22, 2022, for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than December 31, 2024

Oregon *does* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. However, as demonstrated above, none of these categories of service are subject to a required increase under STC 10.2 through the managed care delivery system. For any such payments, I agree to submit the Medicaid managed care plans' provider payment rate increase methodology, including the information listed in STC 10.7 through the state-directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *N/A*
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 10.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Oregon agrees not to use DSHP funding to finance any provider payment rate increase required under STC 10 and will ensure that the entirety of a two-percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans. Oregon further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 10.
I, *Dana Hittle, Interim Medicaid Director,* attest that the above information is complete and accurate. [*Provide signature* [redacted]] [*Provide printed name of signatory* Dana Hittle] [*Provide date* 12/22/2022]

ATTACHMENT L
New Initiatives Implementation Plan

New Initiatives Implementation Plan. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), the New Initiatives Implementation Plan provides additional detail on the strategic approach to implementing Young Adults with Special Healthcare Needs (YSHCN), Health Related Social Needs (HRSN) Infrastructure, HRSN Services, and Continuous Eligibility, including timelines for meeting critical implementation stages and milestones, as applicable, to support successful implementation.

I. New Initiatives Implementation Approach and Timeline. The State will phase-in the implementation of key initiatives over the course of the demonstration. Information for each initiative as required in the STCs is included below.

a. Continuous Eligibility Implementation Activities and Timeline

i. The state's continuous eligibility policy became effective on July 1, 2023, and went live in the Oregon Eligibility (ONE) system on July 20, 2023. New CE policy grants continuous eligibility for children up to age six, and for 24-months of continuous coverage for children and adults over age six.

ii. The continuous eligibility policy applies to all individuals who experienced a renewal as a result of the end of the Public Health Emergency, or newly applied and were found eligible as of April 1 forward, and are still eligible and receiving benefits on July 1, 2023. The state will apply the continuous eligibility period for anyone who meets those criteria by establishing a continuous eligibility begin-date based on their renewal or initial application date. For example, if an adult was renewed in May 2023 and is still eligible on July 1, 2023, the state will begin the 24-month continuous eligibility period for this adult in May 2023.

iii. Systems updates, which went live on July 20, 2023, automatically identifies individuals who are undergoing their post-PHE renewal or newly applying and assign a continuous eligibility period to those individuals. At this time, the system will assign both a continuous eligibility period, and the renewal date will still reflect a 12-month period. There will be a second phase of systems updates in early 2024 that will deploy the system functionality to assign case renewal dates based on continuous eligibility periods present on the case.

b. Health Related Social Needs Implementation Activities and Timeline

i. *DY 21 – DY 22*: Procurement of Essential Vendors

1. The state will procure vendors necessary to deliver HRSN services. Throughout the first two years of the demonstration, the state will procure the following vendors:
    a. *Third-Party Contractor for FFS HRSN Operations:*

The Third-Party Contractor (TPC) will support the HRSN service delivery model for the Fee-For-Service (FFS) population, and may serve as a resource to CCOs should they choose to sub-contract key contractual obligations related to HRSN service delivery as detailed in contracts with Oregon Health Authority. Key activities for the TPC may include:

i. Building a network of HRSN service providers
ii. Providing support and TA to HRSN service providers
iii. Proactively screening for members who may be eligible to receive HRSN services
iv. Accepting referrals from state agencies, providers, community-based organizations, and other entities, for individuals who may be eligible to receive HRSN services
v. Conducting eligibility determination and service authorization
vi. Developing the person-centered service plan
vii. Referring the eligible individual to an appropriate HRSN service provider
viii. Providing care coordination and HRSN care management
ix. Accepting invoices from HRSN providers and verifying invoices are payable
x. Facilitating payment to HRSN providers
xi. Collecting data from HRSN providers and submitting data to OHA for monitoring and reporting
xii. Ensuring provision of services is culturally appropriate and trauma informed

b. The state may also enter into agreements with Tribal organizations to perform HRSN service authorization and related functions for FFS members who are also American Indian/Alaskan Native (AI/AN) like the functions that will be performed by the TPC for non-AI/AN FFS members. The state will work closely with Tribal governments to tailor the operationalization of HRSN services appropriately to the AI/AN community and develop a detailed communications plan to ensure AI/AN individuals

are aware of HRSN services, who is eligible and how to access them.

c. *Administration of HRSN Infrastructure*: The state intends to carry out the essential administrative functions related to HRSN infrastructure disbursement and monitoring in partnership with another contracted entity (e.g., CCOs)*(see Attachment J for additional detail on roles and responsibilities).*

d. *Community Information Exchange for HRSN Service Delivery:* The state intends to procure Community Information Exchange (CIE) vendor(s) to support statewide HRSN screening and referral data sharing for FFS members. These vendors are likely to be aligned with those CIE vendors providing the HRSN data sharing supports to CCOs. Over the course of the demonstration, HRSN providers throughout the state will use CIE to support HRSN data sharing. See Section II.a for additional details on the state's approach to data sharing.

e. The state will also allow CCOs to work with Network Managers to support the development and oversight of adequate HRSN Provider networks across the state.

ii. *DY 21 through DY 25:* Build Community Capacity and Award HRSN Infrastructure Funding

1. In the initial years of the demonstration, the state will focus efforts on capacity building for key entities, (e.g., HRSN providers), to begin delivering HRSN services starting in Calendar Year (CY) 2024. Infrastructure funding disbursement is intended to be "front loaded" in the first half of the demonstration (i.e., DY 21-23), tapering off in the final years (i.e., DY 24-DY 25). In particular, the state intends to conduct the following activities via agreements with CCOs and federally recognized Tribes.
    a. Receive input from the nine federally recognized Tribes, HRSN and community partners on infrastructure funding design and process;
    b. Conduct outreach and education to providers interested in delivering HRSN services on available infrastructure funding and requirements to becoming a HRSN provider;
    c. Provide technical assistance (TA) and support to providers interested in delivery of HRSN services to submit an application to receive infrastructure

funding;

d. Review the submitted applications and award infrastructure funding, as detailed in Attachment J; and,
e. Monitor and oversee the use of infrastructure funding, as detailed in Attachment J.

iii. ***DY 22- DY 25*: Phased Implementation of HRSN Services**

1. Beginning in CY 2024, eligible individuals will be able to receive HRSN services. All members must meet eligibility criteria as set forth in Attachment J: HRSN Services Protocol. Additionally service specific eligibility will apply as detailed in STC 9.2(a). The state intends to phase-in services on the following timeline:
    a. No sooner than March 2024:
        i. The following services for all eligible populations[11]: Medically necessary air conditioners, heaters, air filtration devices, portable power supply (PPS), and refrigeration units as needed for medical treatment and prevention
        ii. HRSN outreach, education and other benefit linkages
    b. No sooner than November 2024:
        i. The following services for populations "at risk of homelessness" who need support to stay in their housing or move into already identified housing:
            1. Rent/temporary housing
            2. Utility costs
            3. Pre-tenancy and housing transition navigation services
            4. Tenancy sustaining services
            5. One-time transition and moving costs and housing deposits Medically necessary home accessibility modifications and

[11] This includes all of the covered populations described in STC Section 9.5 except that described in subsection (g), "[i]ndividuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon." The state determined that it could not meet the needs of this population within the constraints of the STCs. As a result, the state has decided not to include this group as a covered population for purposes of waiver implementation.

remediation services

c. No sooner than January 2025:
    i. The following services for all qualifying individuals:
        1. Nutrition education
        2. Nutrition education and environmental supports
        3. Assessment for medically tailored meals
        4. Medically tailored meals
        5. Meals
        6. Pantry stocking
        7. Fruit and vegetable prescriptions
d. At a date to be determined by the state based on HRSN service delivery experience in the initial DYs, but no sooner than January 2026:
    i. All HRSN services fully phased-in for all eligible populations.

c. Young Adults with Special Healthcare Needs (YSHCN)

i. As part of the YSHCN initiative, the state will implement an expanded OHP YSHCN eligibility and an expanded OHP benefit for individuals in this eligibility category.

ii. The state developed a YSHCN Policy Oversight Team to oversee key policy decisions needed to operationalize YSHCN eligibility, benefit expansion and enrollment in OHP. The team will focus on two distinct scopes of work, including:

1. YSHCN Eligibility: Initial priority is to finalize a final list of behavioral health conditions and codes for YSHCN eligibility related to the second approved waiver criteria: *(see also, Section iii.1.a; and Section iv below for more information on Eligibility)*

a. **STC 4.6.a.ii: Have a serious emotional disturbance or serious mental health illness.**

2. YSHCN Screening and Enrollment: Focus will be on developing a recommendation for a finalized screening tool and enrollment process that is culturally and linguistically responsive, based on review of the Child and Adolescent Health Measurement Initiative's (CAHMI) Children and Special Health Care Needs (CSHCN) Screener. This process will operationalize the pathway to qualify for YSHCN via the fourth approved waiver criteria:
    a. **STC 4.6.a.iv: Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener**,

modeled after the Child and Adolescent Health Measurement Initiative (CAHMI)'s "Children with Special Health Care Needs" (CSHCN) Screener.

iii. YSHCN Eligibility and Enrollment Framework

1. The YSHCN Policy Oversight Team is suggesting three pathways to YSHCN eligibility:
    a. Passive identification and enrollment (data-confirmed eligibility): Health care utilization data are automatically screened for young adults currently enrolled in OHP and nearing their 19th birthday
        i. Utilization matching the PMCA or identified behavioral health diagnostic codes *(see Section I.c.ii.1)* would trigger eligibility for YSHCN coverage as defined by **STC 4.6.a.i - .ii**
        ii. Programmatic eligibility: young adults with a diagnosed intellectual or developmental disability are automatically eligible for YSHCN coverage as defined by **STC 4.6.a.iii**
        iii. Operationalizing: Contractor to review claims data from MMIS, APAC and/or a combination of these sources. young adults flagged in systems for auto- enrollment upon 19th birthday.
    b. Integrated universal screening within the ONE Eligibility system:
        i. The adapted CHSHCN screening tool will be built into the ONE Eligibility system. Individuals aged 19 to 26 will prompted to complete the optional screen.
        ii. Youth complete/partners support young adults to complete CSHCN screen; two or more affirmative answers signal YSHCN eligibility.
        iii. OHA proposes self-attested eligibility for the purposes of YSHCN.
            1. Ensures equitable access with varying health care data availability (such as former foster youth from out-of-state vs. in-state)
            2. Reduces barriers to entry, particularly at launch of the program
            3. Shortens timeline from screening to

final eligibility determination, improving equity between passive and referral enrollment pathways
4. Lowers administrative burden for Tribal Governments, CCOs, other contracted entities, and OHA
5. Risk of false self-attestation perceived to be low

c. Referral and Outreach: In addition to broad general outreach and education to community partners related to YSHCN eligibility and enrollment, specific outreach will be conducted to reach populations with a high degree of potential eligibility but who may not reliably utilize the ONE Eligibility integrated YSHCN screening for enrollment of benefits (for example former foster youth, youth exiting carceral settings). OHA will continue to explore specific referral pathways to ensure access to the YSHCN screening tool.

iv. The timeline and approach will ensure the state collaborates with key partners throughout the design and moving into the implementation of the expanded eligibility and benefit beginning January 2025. The planning and design process will include:

1. Throughout 2023:
    a. Assemble and consult a clinician and advocate panel to inform final set of behavioral health conditions and diagnostic codes for YSHCN eligibility
    b. Finalize review of CAHMI screener to determine cultural and linguistic appropriateness, including family and young adult engagement
    c. Finalize policy questions to inform systems changes and launch systems changes to state systems for claims, eligibility and enrollment (MMIS, ONE Eligibility, and Legacy)
    d. Conduct health equity impact assessment on key policy and program decisions
    e. Develop contract requirements for a data contractor responsible for ongoing mining of claims data for young adults with qualifying conditions for YSHCN (i.e. applying the Pediatric Medical Complexity Algorithm and any supplemental behavioral health

condition codes)

f. Begin financial modeling for CCO contracts

2. Throughout 2024:
   a. Update CCO contracts as needed for CY 2025
   b. Continue implementation of, and finalize, systems changes
   c. Identify and implement needed changes to Oregon Administrative Rules, including Tribal Consultation
   d. Provide education to, and engage with, partner agencies, providers, and members of the public about YSHCN
   e. Secure data contract for claims mining
   f. Run the Pediatric Medical Complexity Algorithm (PMCA) and set flags for individuals who will be eligible on January 1, 2025

II. Data Sharing and Key Partnerships

a. Data Sharing

i. *Overview:* The state will work with CCOs and community partners on an approach to data sharing that meets entities where they are today and supports them toward uptake and the use of shared systems. Closed loop referral technology will provide a mechanism to conduct closed loop referrals and service provision between HRSN providers, the FFS TPC (described above) and CCOs. Data sharing between these entities may include general SDOH screenings, HRSN Request Form, person-centered service plan, and HRSN service referral and delivery status. The state will work with these entities to phase in the use of closed loop referral technology based on readiness and appropriateness, over the course of the demonstration. Today, all CCOs currently sponsor closed loop referral technology use for their service region through the use of two CIE technology vendors. The state intends to contract the same two vendors and provide access to the closed loop referral technology for the TPC to ensure statewide access for members in FFS. OHA will contract to have access to all Medicaid member data related to CIE for analytics purposes.

ii. *Background:* From May through July 2022, the state engaged 99 CBOs statewide to understand views and experiences with CIE and solicit input to inform the state's approach to accelerate, support, and improve statewide CIE efforts.[12] As a result of this work and a

[12] CIE_Community_Engagement_Findings_and_Recommendations.pdf (oregon.gov)

CIE Workgroup of key partners in 2022, the state recommended that CBOs should be incentivized, rather than required, to use CIE.[13,14]

iii. *Approach:* The state, either itself or via a contractor, will incentivize HRSN providers to utilize the closed loop referral technology by offering infrastructure funds to support use of, training on and connection to closed loop referral technology. Further, the state will require CCOs to support and incentivize HRSN providers with closed loop referral technology uptake as part of the CCOs' contractual obligation with the state. The state will support the statewide provision of TA, education, and communities of practice for HRSN providers throughout the duration of the demonstration to ensure a consistent space to support providers with closed loop referral technology uptake.

1. The state will allow for exceptions for HRSN providers to use closed loop referrals as there may be situations where it is not feasible for the providers to participate and may impact equitable access to services for some members (e.g., monolingual non- English speaking HRSN providers). HRSN providers will be expected to use alternative modes to communicate about the status of referrals, services delivered and other required data elements.
2. The state will require CCOs to develop a plan for and report progress on supporting and incentivizing the adoption of closed loop referrals specifically as part of their overall Health IT Roadmaps.[15] This plan will need to include the CCO's approach to outreach, education, and incorporating feedback from HRSN providers. CCOs will also be required to ensure their plan for supporting closed loop referral technology adoption aligns with the SDOH: Social Needs Screening and Referral incentive measure.[16]
3. The state intends to support closed loop referral technology uptake amongst HRSN providers and other entities participating in the HRSN initiative.

iv. *Reporting on HRSN-Related Data*. The state will require HRSN

- [13] CIEWG_PrelimRecs.SupportforCBOstoParticipateinCIE.pdf (oregon.gov)
- [14] https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/HB4150FinalReport.SupportingStatewideCIE.pdf
- [15] Oregon's CCOs are required to submit Health IT Roadmaps to OHA each year outlining their strategies to accomplish Health IT goals. Redacted roadmaps are available at https://www.oregon.gov/oha/HPA/OHIT/Pages/HITAG.aspx
- [16] https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

partners, including, for example: CCOs, FFS TPC, HRSN providers and others to maintain and report on key data elements related to HRSN service delivery. Data will be stratified by key demographic subpopulations, including: sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography. The state, in collaboration with HRSN partners, will be required to track and report on the following key data elements, at a minimum:

1. Number of members who have been screened for HRSN services (i.e., the number of members who have had an HRSN service requested)
2. Number of members currently referred and authorized to receive an HRSN service (listed by service)
3. Number of members denied for HRSN services (listed by service)
4. Number of members who have received an HRSN service (listed by service)
5. Data to support evaluation of HRSN program, including, for example:
    a. Data on improvements in member health-related resource needs.
    b. Data on member health outcomes, if applicable
6. Other data required by the state and the demonstration's STCs.

v. Partners will be required to use strategies to meet these requirements which may include the need to modify existing methods to track the information above or develop new strategies to meet these requirements.

b. Key Partnerships and Approach to Soliciting Community Partner Feedback Cross-sector and community-based partnerships are essential to the successful delivery of HRSN services to eligible members and promotion of health equity. The state has developed the following approach to engaging with and incorporating input from impacted partners, including HRSN providers, CCOs, members and others.

i. *Partner and Community Engagement Strategy:* The state has developed a strategy to ensure engagement across a diverse set of key partners involved in the design and implementation of HRSN services. OHA developed this strategy in partnership with sister agencies OHCS and ODHS to identify key partners and develop an effective engagement approach. As part of this focused engagement approach, the state will work with distinct audiences, including:

1. Tribal governments and AI/AN members
2. Contract holders (i.e. CCOs and FFS entities)
3. Direct HRSN service providers (i.e. housing and nutrition CBOs)

4. Oregon Health Plan members
5. Others, as identified through continued engagement efforts by the state

ii. *CCO Partnership:* Through the current provision of related initiatives (e.g., health-related services (HRS)), CCOs have developed robust provider networks, partnerships, and expertise in several areas, including, for example:
   1. Care coordination, navigation and case management activities
   2. Food services and supports, including vouchers, meal delivery, and farmers' markets
   3. Housing services and supports, including temporary housing or shelter, utilities, critical repairs, air conditioners, items to improve mobility, and environmental remediation
   4. Trauma-informed services and supports across sectors

iii. The state will support CCOs in building upon these existing networks, partnerships, and resources to now provide HRSN in addition to the continuation and coverage of Health-Related Services (HRS).

iv. The state will require CCOs to have networks of HRSN providers to sufficiently meet the needs of their members for nutrition and housing services, including culturally and linguistically appropriate and responsive services.
   1. To inform this design, the state has and will continue to engage with CCOs on a regular basis through forums such as the:
      a. Regular meetings with CCOs specifically related to HRSN
      b. Monthly Operations Collaborative
      c. Monthly CCO Contracts Group
      d. Rate Workgroup

v. *Climate Specific Partnerships:* The state has been working with vendors since 2021 to establish partnerships for the purchase and distribution of air conditioners and air filtration devices to older and at risk Oregonians to protect their health and well-being in the event of extreme heat and wildfire smoke. The state will build on these partnerships to expand the types of devices and formalize the distribution processes to deliver these services to eligible populations.

III. Partnerships with State and Local Entities

a. The state intends to develop robust partnerships with other state and local agencies to help assist Medicaid members in obtaining non-Medicaid funded supports related to housing and nutrition, upon the

conclusion of temporary Medicaid payment via the HRSN services program.

i. Medicaid is not intended to cover the cost of social supports for individuals in perpetuity. The state will develop strong partnerships state and local entities that prepare a pathway to providing whole person care in a sustainable way.

ii. The HRSN program provides an opportunity to formalize existing and develop new partnerships between the Medicaid delivery system and other federal, state and local initiatives that support improved health and wellbeing.

b. At a minimum, the state will undertake the following efforts to develop partnerships with key entities listed below:

i. **Continuums of Care**. The state has active Continuums of Care (CoCs) that develop locally appropriate strategies to end homelessness. Throughout the demonstration, the state seeks to formalize partnerships between the Medicaid delivery system and CoCs. For example, the state will encourage CCOs to be active partners by joining the board, attending meetings, or joining sub-committees of their local CoC to build the relationships with their local housing partners. The state, in partnership with other entities, including CCOs and CoCs, will consider opportunities to support identification of additional housing resources that members may require, and to provide a more sustainable funding source for ongoing services beyond what is covered under Medicaid. As part of this partnership, the state is exploring ways to support CCOs to connect to the Homeless Management Information System (HMIS) in a way that preserves informed consent and creates mechanisms for sharing sensitive data cross-sectors. Additionally, the state will encourage CCOs to have their care coordinators, and intensive care coordinators become Coordinated Entry (CE) access points, along with any other member facing positions the CCO may have that could serve as a connection to CE. State convenings on HMIS data sharing are underway and will continue as part of this effort. The state intends to pursue these partnerships in advance of launching the housing services in November 2024.

ii. **Local Public Housing Authorities.** The state will seek to formalize and oversee partnerships between OHA and local housing authorities over the course of the demonstration. Specifically, the state will seek to identify opportunities to provide additional and longer-term housing supports to members beyond what is covered through HRSN or other Medicaid initiatives, including through partnerships with CCOs, the FFS TPC staff, local housing authorities and others. For example, CCO care coordination staff

can work with local public housing authorities to identify funding sources to support rental payments and/or housing units for members beyond the six month's rent service covered through Medicaid. The state intends to pursue these partnerships in advance of launching housing services in November 2024.

iii. **Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC).** Oregon Health Authority works closely with the Oregon Department of Human Services (ODHS), which is the state department that administers SNAP. OHA administers the WIC program. The launch of the HRSN initiative provides the opportunity for more close coordination between the state agencies to maximize enrollment in federal and state programs. Through these partnerships, the state will identify opportunities to ensure eligible individuals are seamlessly enrolled in other federal and state programs for which they are eligible—including SNAP and WIC. Efforts to promote these connections include identifying opportunities in the HRSN design to establish requirements for CCOs, HRSN providers and others, that support the goal of connecting members to SNAP, WIC and/or other federal and state programs for which they are eligible. The state intends to pursue these partnerships by the launch of the full suite of nutrition services, in January 2025.

IV. Information Technology Infrastructure

a. The state will ensure appropriate updates to existing IT infrastructure to support and promote the successful delivery and monitoring of HRSN services.
   i. Specifically, the state is updating state eligibility systems to reflect the eligible HRSN populations and services, as well as updates to the Medicaid Management Information System (MMIS) to appropriately support encounter information for payment processing.
   ii. There is a process underway for identifying required data elements for encounter files to enable actual reporting of HRSN services delivered by the CCO or FFS.
   iii. The state intends to develop a plan to enable data exchanges between various systems and state agencies to make sure that HRSN services are only offered when eligible individuals are not covered under other state programs.
   iv. The state is building a technology roadmap to outline all system requirement changes needed to track and report on HRSN services.

b. **Infrastructure for Invoicing for HRSN Services Delivered**. HRSN providers will be required to send invoices for the delivery of authorized

HRSN services to either the CCO or the FFS TPC, based on the member.

i. For CCOs, the CCO will be responsible for processing the invoice and issuing the payment to the HRSN provider. CCOs will generate an encounter for the service provided and send encounter data to the state.
ii. For FFS, the TPC will be required to process the invoice and generate Electronic Data Interchange (EDI) claims transactions that are sent to the state. The state will use MMIS to ingest encounter information from the FFS TPC and draw on those encounters for payment processing. The state is developing appropriate systems to ensure encounters can be reviewed, revised if needed, and accepted or denied.

c. **Monitoring and Oversight**. The state will require HRSN partner, including CCOs, HRSN providers and others—to maintain program integrity standards in the HRSN program, leveraging existing or new IT infrastructure to conduct activities, including, for example:
   i. Tracking payments to HRSN providers for HRSN services delivered and monitoring for outliers;
   ii. Conducting invoice analysis to avoid payment irregularities (e.g., over or underpayment);
   iii. Conducting quarterly accounting on HRSN services delivered;
   iv. Performing visit verifications to ensure individuals received the HRSN services for which they were authorized to receive; and,
   v. Other activities required by the state.
d. The state is developing a plan to make sure that data is available for outcomes and CMS reporting, including data from other state agencies.
e. The state is continuing to explore future data integrations and connections that will create a sustainable statewide system, including infrastructure for a statewide consent tool.

V. SNAP, WIC, TANF, and Housing Assistance Program Enrollment. The state will use a multi-faceted approach to improve the share of beneficiaries enrolled in SNAP, WIC, TANF and other federal and state housing assistance programs ("key benefits").

a. Policies to Support Key Benefit Enrollment for Members Receiving HRSN Services. As described below, the HRSN services member journey is being designed to ensure the members receiving HRSN services are also applying for and maintaining other key benefits for which they may be eligible.

i. **Included on the HRSN Request Form.** This form will include a section on whether a member is interested in enrolling in key benefit programs, to be completed by the identifying entity or CCO/TPC as applicable.

ii. **Required as a Component of the Person-Centered Service Plan (PCSP).** First, the state will leverage HRSN Outreach & Engagement Service providers CCOs and the FFS TPC to support member enrollment in key benefit programs through the person-centered service planning process. As part of the process, CCOs and the TPC will review the key benefit information provided as part of the member's HRSN Request Form and then as needed, inquire further about the member's enrollment in key benefit programs in person, by phone, or through follow-up with the identifying entity. In its telephonic or in-person contact with the member, the CCO/TPC will be expected to confirm the information it has gathered to date about the member's enrollment in key benefits, and then include in the PCSP, a plan for supporting or maintaining the member's enrollment in key benefits for which the member is likely eligible.

iii. **Supporting Referrals for Key Benefit Application Assistance.** Upon a determination of member likelihood to meet eligibility criteria and interest in applying for key benefits, the CCO/TPC care manager or the HRSN Outreach & Engagement Service provider shall make referrals to help the individual apply for benefits. The state expects that referrals will be made to the local ODHS office (for TANF and SNAP) and the local WIC office, as well as other organizations that can assist an individual, or direct an individual to assistance, for the eligibility and enrollment process, such as 211, and other community partners including, but not limited to, HRSN contracted providers. In determining the appropriate referral, the CCO/TPC shall consider, first and foremost, the organization who is most likely to succeed in engaging with the member and supporting their enrollment in key benefit programs, such as an organization that has a trusted relationship with the member, is culturally and linguistically responsive, or that is or will be providing other services to meet the member's needs (whether HRSN waiver services or not). The CCO/TPC care manager will be required to follow up with the member on any referral and provide additional referrals or direct support as needed to facilitate the member's application for key benefits. If the member's application is deemed incomplete or denied, the care manager will be expected to ensure the member receives assistance, including by referral to an organization that can provide the assistance as needed, to submit any missing information or appeal the denial, if the member wishes to pursue an appeal. All efforts to connect the member to key benefits must be documented in the PCSP. As part of its oversight of CCO/TPC administration of HRSN services, OHA will require

CCO/TPC reporting on compliance with these requirements, conduct its own monitoring activities (e.g., spot audits), and where significant deficiencies are found, require corrective action by the CCO/TPC.

iv. **Included as An Element of Several Covered HRSN Services.** To support key benefit enrollment, providing help with securing, utilizing, and maintaining benefits will be included in the HRSN service definitions and rate development for the following HRSN services[17]:

1. Pre-tenancy and housing transition navigation services,
2. Tenancy sustaining services, and
3. Outreach, engagement, and benefit linkages service

b. **Supporting Key Benefit Enrollment for All Medicaid Members.** The state will also seek to implement other policies designed to ensure that all Medicaid members, whether receiving HRSN services or not, have the appropriate supports needed to learn about and apply for the key benefits they need. Policies being implemented, developed, or under consideration include the following:

i. **Seeking Authorization for Application Assistors to Assist with Medicaid *and* SNAP.** The state is developing and seeking authorization for a pilot program from Food and Nutrition Services (a program of the United States Department of Agriculture) to offer help to individuals applying for SNAP. For the pilot, forty (40) contracted Medicaid application assistors would have the option to attend additional training to provide application help for SNAP applicants. Additionally, the twelve (12) contracted SNAP outreach organizations would have the option to help SNAP and/or Medicaid applicants access these benefits.

ii. **Enhanced Training Requirements for CCOs/TPC.** The state may consider requiring that CCO/TPC care managers receive training on how to help members in completing the written unified application for SNAP and TANF; support a member in real-time in connecting with 211 and working with the appropriate assistor to apply for key benefits and enroll in the local CoC's coordinated entry system (if available through 211); or submit a request online through the WIC site so that the member receives a call back to support WIC enrollment.

iii. **Learning Collaboratives.** The state may also consider hosting learning collaboratives for CCOs and the TPC with contracted HRSN providers, relevant state agencies, and other partners to

[17] Individuals may not receive more than one of the above services at the same time, to avoid duplication.

share learnings on best practices in engaging with members to support their success in applying for and obtaining key benefits.

iv. **Member Input.** The state may consider requiring that CCOs use their Community Advisory Councils to seek input on how they can more effectively support members in connecting to key benefits, and report back on the feedback received through the discussions, and how the CCO plans to respond to this feedback, as part of their required reporting to the state on their advisory committees' activities.

c. **Data Tracking and Monitoring**

i. **Current Data Warehouses for Key Benefits**. Currently, enrollment information for Medicaid, TANF, and SNAP is housed in Oregon's unified Oregon Eligibility (ONE) system. Information on WIC enrollment is housed in a separate state database, and information on receipt of housing assistance in separate local versions of HMIS, held by the state's eight continuums of care. On a quarterly basis, the local Community Action Agency and CoCs share OHCS funded data with OHCS for inclusion in a statewide database.

ii. **Cross-Program Data Matching.** To support the state's effort to track and increase the share of Medicaid enrollees who are enrolled in key benefits, the state will conduct an annual cross-program data matching analysis to identify Medicaid enrollees who are likely eligible for but not enrolled in key benefits. The analysis will be conducted by the Integrated Client Services (ICS) division of the Oregon Office of Forecasting, Research, and Analysis (OFRA), an office that supports both OHA and the Oregon Department of Human Services (ODHS) ICS has experience and expertise in creating integrated data sets that involve cross-program data matching for State programs, including Medicaid, TANF, and WIC. ICS currently receives nutrition program enrollment information monthly and has an established process for obtaining the necessary data permissions, collecting and warehousing the data,, producing the data results, and sharing it with the state agencies that contributed data for the analysis results. While OHCS and HMIS data is not currently available to ICS, OHA plans to partner with ICS in developing a strategy for using any data that can be obtained to track Medicaid member enrollment in state and federal housing assistance programs.

VI. Continuous Eligibility Member Verification

a. Beneficiary-Reported Information and Periodic Data Checks

i. The state will ensure that beneficiaries can make timely and

accurate reports of any changes in circumstances, including changes to state residency or income. Beneficiaries will be able to report this information

ii. On at least an annual basis, the state will continue to verify residency, and confirm the individual is not deceased for all beneficiaries.

iii. To verify residency:

1. Subject to final approval from CMS, the state intends to use the quarterly Public Assistance Reporting Information Systems (PARIS) report to check which individuals are receiving concurrent benefits in another state.
2. Drawing on the PARIS report, the state will continuously analyze the quarterly PARIS report and confirm with other states that these individuals have applied and attested to being a resident in another state. If confirmed, eligibility for the Oregon Health Plan (OHP) will be terminated. If the state is unable to confirm, the individual will remain on OHP.

iv. To verify if a member is deceased:

1. The state will continue to use the same process and systems in place today. The Oregon Eligibility (ONE) system interfaces with the State Data Exchange (SDX), Beneficiary Earnings and Data Exchange (BENDEX) and Vital Stats databases to receive and track information related to the death of a member, and terminate coverage effective on the date of death.
2. Additionally the state receives a "Death File Report" from the Social Security Administration, which serves as a secondary check to the file received from SDX.
3. The state also received a "Do No Pay" report, which is a compilation from the American InfoSource, the SSA Death Master File, the Department of Defense Death Data, and the Department of State Death Data. The state uses this file as another check for records in the ONE system.
4. Once a month, the Medicaid Management Information System (MMIS) interfaces with data from the state Public Health Division. This interface automatically adds death date indicators in MMIS for deaths that occurred in the previous month, which leads to CCO disenrollment and initiates the prorated recoupment process.

b. Annual Updates to Beneficiary Information

i. The state clearly communicates reporting requirements, including updates to residential and mailing address and other contact information, on all eligibility correspondence with applicants and

beneficiaries. Beneficiaries may report such changes online, in person, by telephone or by mail.

ii. The state will rely on this, in coordination with information available from resources described above, to maintain accurate beneficiary contact information. Additionally, reported changes relating to other OHA or ODHS benefits (SNAP, TANF, ERDC, etc.) will be considered for medical beneficiaries.

VII. HRSN Rate Methodologies

a. OHA to submit to CMS at least 60 days prior to implementation.

VIII. MOE

a. OHA submitted to CMS December 22, 2022.

ATTACHMENT M
Monitoring Protocol

(reserved)

ATTACHMENT N
Prioritized List Phase-Out Plan

(reserved)

ATTACHMENT O
Evaluation Design

(reserved)

APPENDIX: Description of State Operations

1. **Health IT.** The CCOs are directed to use health IT and support the implementation and use of health IT to link services and providers across the continuum of care to the greatest extent possible. The CCOs are expected to support the achievement of minimum standards in foundational areas of health IT and to develop their own goals for transformational areas of health IT use.

    a. **Health IT:**

        i. CCOs must have plans for using health IT and supporting health IT adoption and use among contracted providers. This will include creating a pathway and/or a plan for adoption of health IT (using certified EHR technology when possible) and the ability to exchange data with and between providers outside their organizational and systems' boundaries to coordinate whole person care. If providers do not currently have this technology, there must be a plan in place for supporting adoption. CCOs' plans must also include support for community-based organizations to participate in capturing and exchanging social needs and services information using technology.

        ii. OHA may monitor CCOs' capacity to leverage EHRs for quality, for example, in relation to the CCO quality incentive program and Value-Based Purchasing.

        iii. The state will support communities' health IT infrastructure efforts in all regions (e.g., counties or other municipalities) to exchange health and social needs and services information.

        iv. These state efforts and any requirements for CCOs must align with Oregon's state Medicaid health IT plans.

2. **Innovator Agents and Learning Collaboratives.** State shall utilize innovator agents to serve as an immediate line of communication between the CCO and the Oregon Health Authority. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the demonstration's goals of improving quality and access while managing costs, the state will:

    a. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.

    b. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the state will plan and execute intensified technical assistance.

c. The information in (a) and (b) above will be incorporated into the CCO contracts.

3. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10, 42 CFR 438. 3(j) and 42 CFR 431.20, the state may allow the use of electronic methods for the beneficiary and provider communications as required by:

- 42 CFR 438.10(c) – Special rule for mandatory enrollment states – timeframes for providing information;
- 42 CFR 438.10(e) – Information for potential enrollees;
- 42 CFR 438.10(f)(2) and (3) – Right of enrollee to request and obtain information;
- 42 CFR 438.10 (g)(2) and (3) – Information for enrollees-Enrollee handbook, Other plan information, including PIPs;
- 42 CFR 438.10(h)(2), (3) and (4) – Information for enrollees-Provider directory, including PIPs;
- 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
- 42 CFR 438.102(b)(1)(i) and (ii) – state policies on excluded services.

a. The state may allow the use of such electronic communications only if all of the following are met as required by 42 CFR 438.10(c)(6);

b. The format is readily accessible;

c. The information is placed in a location on the state or CCO's website that is prominent and readily accessible;

d. The information is provided in an electronic form which can be electronically retained and printed;

e. The information is consistent with the content and language requirements of this section; and

f. The enrollee is informed that the information is available in paper form without charge upon request and provides it upon request within five (5) business days.

4. **Transparency/Public Reporting.**

a. The state must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).

b. The state shall publish data regarding CCOs' performance on state-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the state's progress toward achieving the primary goals of this demonstration.

5. **State Oversight of the CCOs.** The state Agency must have in effect a monitoring system for all managed care programs as required per 42 CFR 438.66 in its entirety, as well as ensure through contracts between the State and a CCO, the collection of encounter data as required by 42 CFR 438.242(4)(c).

6. **Additional Quality Measures and Reporting at the CCO Level.** The CCOs will be required to collect and validate data and report to the state on metrics as described in this section. CMS also encourages the CCOs to report on the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP.

    a. **Metrics to track quality improvement.** The state will ensure the collection, analysis, and use of measures to drive quality improvement efforts for Medicaid and CHIP members which will be detailed in the state Medicaid Quality Strategy, inclusive of the quality measures and reporting at the CCO level.

    b. **Core set of quality improvement measures.** The state will track measures to include Adult and Child Core Set measures (as updated annually), additional Consumer Assessment of Health Care Providers and Systems (CAHPS) or other member/patient experience of care measures, and upstream measures identified through public committee processes. In public reporting of these measures, the state will stratify by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography where possible.

    c. **Access improvement measures based on CCO data.** The state and CMS identified and agree to additional access measures. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.

        i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).

        ii. Percentage of adults with any outpatient visit.

        iii. Percentage of adults with a chronic disease with any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).

        iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.

v. Percentage of children with at least one dental visit.

vi. Fraction of physicians (by specialty) 'participating' in the Medicaid program.

vii. Change in the number of physicians (by specialty) participating in Medicaid.

viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).

ix. Percentage of CCO enrollees with access to a PCPCH.

d. **Access improvement measures based on state survey data.** The state will continue to field CAHPS or a similar member/patient experience survey to track access measures in the survey and will publicly report results.