Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
Health Services
Office of Medical Assistance Programs
500 Summer Street NE, E49
Salem, OR 97301-1077
Voice (503) 945-5772
FAX (503) 373-7689
TTY (503) 378-6791

September 5, 2003

The Honorable Tommy Thompson
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Thompson:

Since 1994, Oregon has operated a Medicaid demonstration program that has expanded health insurance to over 1 million individuals. The state is fully committed to continuing this program, but in the midst of a severe budget crisis, continuation will not be possible without some restructuring.

Oregon is requesting approval from the Centers for Medicare and Medicaid Services (CMS) of the following amendments to our Health Insurance Flexibility and Accountability (HIFA) / Section 1115 demonstration, known as the Oregon Health Plan (OHP)[1]:

1) Movement of the line on the Prioritized List of Health Services from line 549 to line 519;

2) Redefinition of the OHP Standard benefit package;

3) Flexibility to adjust optional benefits for OHP Plus adults depending on available state funds;

4) Addition of a new program called the Medical Expansion for persons with Disabilities and Seniors (MEDS);

5) Expansion of coverage under the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP) from 185 to 200 percent of the Federal Poverty Level (FPL).

All of these requests will be funded within Oregon's current OHP budget neutrality agreement. We plan to submit revised budget neutrality calculations to CMS on or before September 19.

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[1] Project number 21-W-00013/10 and 11-W-00160/10

Approval of the first two amendments is critical for continuing the Oregon Health Plan. Approval of our proposed MEDS program will permit Oregon to provide critical prescription drug support for low-income seniors and persons with disabilities within state budget constraints.

Oregon's current economic landscape

Oregon is in fiscal crisis. The state's unemployment rate is the highest in the nation for the second straight year, and revenues are in sharp decline. As a result, there is insufficient funding to sustain the OHP as approved in the HIFA waiver/Section 1115 amendments granted in the fall of 2002. Nonetheless, Oregon's Governor and Legislature remain committed to preserving the OHP if possible, in substantially the same form but with additional flexibility on benefits and eligibility.

The package of changes requested in this amendment application reflects the consensus reached by the Governor and Legislative leadership on the crucial issues of benefits and populations to be covered. The letter submitted to you on June 6, 2003 outlined the initial framework for this consensus (see Appendix A). A tremendous amount of discussion and hard work followed, ultimately crystallizing into House Bill 2511, the OHP restructuring bill passed by the 2003 Oregon General Assembly (see Appendix B).

Savings from this package of amendments are necessary if the OHP is to be preserved. One critical part of the OHP demonstration is the Family Health Insurance Assistance Program (FHIAP). FHIAP subsidizes private health insurance coverage for low-income families and individuals. Implemented in 1998, it was funded with state resources only for its first four years, until it became a part of Oregon's Medicaid program with the approval of the state's HIFA waiver/Section 1115 amendments in the fall of 2002.

Without the savings associated with our current proposed amendments, Oregon may be forced to relinquish the demonstration authority that grants matching funds for FHIAP. It would not be feasible for Oregon to continue the current FHIAP program with state funds only, given the state's fiscal situation. The result would be the loss of approximately 6,000 people currently enrolled, and thousands more who would have been enrolled had the program continued.

In addition, the loss of this demonstration would mean the dismantling of OHP Standard, which currently provides coverage to around 60,000 individuals in the adult population with incomes under the federal poverty level.

Brief overview of the current Oregon Health Plan and future restructuring

As approved on October 15, 2002, clients under the Oregon Health Plan (OHP) demonstration receive services through two types of coverage: OHP public coverage (through the OHP Plus or OHP Standard benefit packages) or private health insurance coverage (through the Family Health Insurance Assistance Program).

Phase I of our current demonstration began on November 1, 2002, with the expansion of FHIAP. At that time, uninsured Oregonians with incomes up to 185 percent of the Federal Poverty Level (FPL) became eligible to receive premium subsidies for the purchase of individual or group (employer-sponsored) health insurance.

On February 1, 2003, Oregon implemented the OHP Plus and OHP Standard portions of our demonstration. OHP Plus is the benefit package provided to individuals eligible under Oregon's Medicaid and SCHIP State Plans.[2] OHP Standard is the reduced benefit package provided to low-income adults (up to 100 percent of the FPL) who meet the HIFA definition of expansion and are eligible only through virtue of our existing[3] 1115 demonstration.[4]

Beginning February 1, 2003, we increased the income levels under OHP Plus for State Children's Health Insurance Program (SCHIP) children and Poverty Level Medical (PLM) pregnant women and their newborns from 170 to 185 percent of the FPL.

Under our existing demonstration, Oregon has approval to expand OHP Standard coverage to adults with incomes up to 185 percent of the FPL. However, as specified in the June 6 letter and in a letter submitted to CMS on May 16, 2003, Oregon is unable to expand OHP Standard beyond 100 percent of the FPL due to severe revenue shortfalls.

As our demonstration moves forward, Oregon is proposing that further expansion under the OHP public program shift from covering adults over the FPL to expanding coverage for SCHIP children from 185 to 200 percent of the FPL, as outlined in the June 6, 2003 letter. More recently, the Oregon legislature has decided that coverage under the FHIAP program will also expand from 185 to 200 percent of the FPL for all eligible uninsured individuals.

For further background, please see Appendix C, which provides an overview of coverage levels for current and newly proposed OHP populations. Appendix D provides a summary of which OHP populations will be impacted by our proposed amendment requests.

Discussion of amendment requests

1) Movement of the line on the Prioritized List of Health Services from line 549 to line 519

As discussed in the June 6, 2003 letter, Oregon is requesting approval to move the line on the 2003-05 Prioritized List of Health Services from line 549 to line 519. This line movement is a necessary part of our waiver amendment package, as it helps provide a significant portion of the financing needed to maintain coverage of our existing optional and expansion populations.

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[2] Demonstration Populations 1-9, 13 & 15 in Oregon's HIFA/Section 1115 Award Letter, dated October 15, 2002.
[3] Our 1115 demonstration known as the "Oregon Health Plan" was initially granted in March 1993.
[4] Demonstration Populations 10-11, 17 & 18 in Oregon's HIFA/Section 1115 Award Letter, dated October 15, 2002.

Clearly, there are treatable conditions on lines 520-549, but they are not in and of themselves life-threatening. The methodology for ranking health services and the resulting list of prioritized services was reviewed and approved by the Secretary of Health and Human Services when the original OHP waiver was granted. There is a safety net for some uncovered conditions built into the implementation of the prioritized list because of the comorbidity rule. The comorbidity rule, briefly summarized, says that we cover uncovered conditions if they are seriously affecting a covered condition and treating the uncovered medically-related condition will significantly improve treatment of the covered condition. This comorbidity process was included with the original approval of the OHP waiver. Alternatively, if an uncovered condition worsens to the point that the diagnosis code changes to a covered condition, then coverage is available.

2) Redefinition of the OHP Standard benefit package

As approved in the Terms and Conditions of our existing demonstration, the OHP Standard benefit package is defined as Medicaid mandated benefits, subject to cost sharing, overlaid by Oregon's Prioritized List.

Oregon is requesting approval to redefine the benefit package for OHP Standard to consist of a core set of fixed services. The benefits would still be subject to cost sharing and overlaid by Oregon's Prioritized List. In addition, the state requests ongoing flexibility to add or remove services that are not part of the fixed set of OHP Standard services, depending on available state funds and the OHP budget neutrality agreement.

As directed by House Bill 2511, the fixed set of services for OHP Standard will include:

- physician services
- ambulance
- prescription drugs
- laboratory and x-ray services
- medical supplies
- outpatient mental health
- outpatient chemical dependency services
- emergency dental services

In addition to these fixed benefits, OHP Standard will initially include hospice and a limited hospital benefit. Based on appropriated funds, the limited hospital benefit will cover emergency services and admission for those conditions for which prompt treatment will prevent life threatening health deterioration.

There are several important benefits to reconfiguring the Standard benefit package. First, it will enable Oregon to provide services to the Standard population that this population does not currently receive, including outpatient mental health and chemical dependency, medical supplies, and emergency dental services. In addition, the reconfigured benefit package will provide primary and preventive services to help OHP Standard individuals care for themselves in a timely manner, thereby reducing long-term complications of chronic disease and hospitalizations.

The OHP Standard population meets the HIFA definition of an expansion population. The benefit package proposed for this population under this amendment is consistent with the benefit package required under HIFA for expansion populations.

Cost-sharing requirements under the reconfigured Standard benefit package will remain as outlined in our demonstration application of May 31, 2002, with the exception of some dental copayments.

3) Flexibility to adjust optional benefits for OHP Plus adults depending on available state funds

Initially, the benefit package for the OHP Plus population will be the Prioritized List of Health Services (funded through line 519). Oregon is requesting the flexibility to reduce or eliminate dental services and/or optional provider services for OHP Plus adults age 19 and older, if necessary to sustain the program within available state funds.

Potential changes to the OHP Plus benefit package for adults involve only optional Medicaid services; mandatory Medicaid services would continue to be available to this population, within the limits of the Prioritized List of Health Services.

4) Addition of a new program called the Medical Expansion for persons with Disabilities and Seniors (MEDS)

As directed by House Bill 2511, Oregon requests an amendment to our existing HIFA/Section 1115 demonstration to incorporate the newly-created Medical Expansion for persons with Disabilities and Seniors (MEDS) program. MEDS is designed to provide a limited benefit to low-income persons with disabilities and seniors over age 65, not otherwise covered under any public or private prescription drug program. Initially, the MEDS benefit package will include only prescription drugs. However, as a part of this amendment, Oregon requests authority to add mental health and/or chemical dependency services to the MEDS benefit package, depending on available state funds.

Approval of this amendment will enable Oregon to make prescription drugs and potentially other valuable services mentioned above more affordable to low-income elderly and persons with disabilities who are not otherwise eligible for Medicaid. Individuals receiving prescription drugs under MEDS will pay a percentage of the Medicaid price of the prescription drug and the dispensing fee. Since enrollment in this program will be limited according to available state funds, Oregon is currently undertaking a process of public input and budget modeling around various cost-sharing options, to determine which cost-sharing levels will enable the state to maximize adequate coverage of eligible individuals.

In February 2003, budget constraints forced the state to eliminate the previous Medically Needy program, which provided prescription drugs, mental health and chemical dependency services to the elderly and persons with disabilities. With a limited amount of funding, the legislature was able to temporarily reinstate a limited

pharmacy benefit with state-only funding to a small subgroup of former Medically Needy clients (individuals with HIV or who had undergone transplants). Approximately 300 individuals in Oregon currently receive coverage through this state-only program. Oregon is requesting permission to permanently grandfather this subgroup of clients into the MEDS program.

In making budget decisions for the 2003-05 biennium, the state considered reinstating a Medically Needy program through our State Plan, but this option would not give us the necessary cost control mechanisms to operate a program within available state resources. Compared to an administratively complex Medically Needy program, our proposed MEDS program will enable us to channel more resources into direct services.

Oregon is requesting approval to incorporate the MEDS program into our HIFA/Section 1115 demonstration and to fund it under the state's existing OHP budget neutrality agreement.

5) Expansion of coverage under the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP) from 185 to 200 percent of the Federal Poverty Level (FPL)

Given the state's budget crisis, Oregon has not been able to implement an expansion of OHP Standard above 100 percent of the FPL, as proposed under our 2002 HIFA waiver/Section 1115 amendments. However, the recently passed House Bill 2511 directs Oregon to expand coverage in two other priority areas – uninsured children under age 19 and uninsured individuals eligible for premium assistance through FHIAP. If approved by CMS, the state will increase the income limit under SCHIP and FHIAP from 185 to 200 percent of the FPL. These efforts will build upon our earlier HIFA expansions, implemented in November 2002 and February 2003.

The proposed expansion of SCHIP and FHIAP from 185 to 200 percent of the FPL will be integrated into the revised budget neutrality calculations.

Conclusion

This proposed package of amendments to our HIFA/Section 1115 demonstration will allow Oregon to maintain a modest but significant expansion of the Oregon Health Plan, to implement a restructured benefit package for the OHP Standard population that is more broad-based and affordable, and to implement the Medical Expansion for persons with Disabilities and Seniors (MEDS) program.

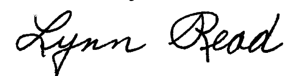
We believe the OHP demonstration is a valuable framework to provide health insurance to low-income Oregonians through both the public and private sectors. If these amendments are not approved and the state is unable to continue the demonstration (including OHP Standard and FHIAP), the result will be the loss of health insurance for tens of thousands of individuals throughout Oregon and the reversal of 15 years of progress towards health care coverage for all Oregonians. Our desire is to work

collaboratively with you in moving our amendment requests through CMS clearance as quickly as possible to ensure the viability of the demonstration.

Oregon hopes to implement these waiver amendments on January 1, 2004. To accomplish that, we respectfully request CMS approval by October 15, 2003.

Thank you in advance for your expedited review of these amendment requests. If you have any questions or would like further information, please do not hesitate to contact me at (503) 945-5767.

Sincerely,



Lynn Read
Administrator

C: The Honorable Gordon H. Smith, U.S. Senator
The Honorable Ron Wyden, U.S. Senator
The Honorable Earl Blumenauer, U.S. Representative
The Honorable Peter DeFazio, U.S. Representative
The Honorable Darlene Hooley, U.S. Representative
The Honorable Greg Walden, U.S. Representative
The Honorable David Wu, U.S. Representative
Theodore R. Kulongoski, Governor
Erinn Kelley-Siel, Governor's Office
Jean I. Thorne, Department of Human Services
Karen Minnis, Speaker, House of Representatives
Peter Courtney, Senate President
Tom Scully, Administrator, CMS
Dennis Smith, CMS
Mike Fiore, CMS
Sidney Trieger, CMS
Donna Schmidt, CMS
Karen O'Connor, CMS, Region X
John Toth, CMS, Region X

Appendices

Appendix A, Letter to Secretary Tommy Thompson, June 6, 2003

Appendix B, House Bill 2511 Enrolled

Appendix C, Overview of Coverage Levels for Current and New OHP Populations

Appendix D, Overview of OHP Populations Affected by Amendment Requests

Appendix A

Letter to Tommy Thompson
June 6, 2003

June 6, 2003

The Honorable Tommy Thompson
Secretary of Health and Human Services
US Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Thompson:

As you know, Oregon has been faced with unprecedented revenue shortfalls over the past two years. This has necessitated dramatic reductions in expenditures for services throughout government, including the Oregon Health Plan (OHP). This has required that we utilize almost all the flexibility you provided us through the OHP2 waivers granted on October 15, 2002. Although we did expand coverage for pregnant women and children from 170% of the federal poverty level (FPL) to 185% of the FPL, as well as support and expand employer-subsidized insurance to 185% of the FPL through the Family Health Insurance Assistance Program (FHIAP), at the same time we were required to reduce benefits to non-categorical adults under the FPL, known as the OHP Standard population. From the original benefit design submitted as part of our waiver request, we then eliminated coverage in the order included in that request, i.e. limited dental, medical supplies and outpatient mental health and chemical dependency services. We also eliminated coverage for prescription drugs, but quickly reinstated that coverage. In addition, we eliminated our Medically Needy program, which provided prescription drugs, mental health and chemical dependency services to the elderly and persons with disabilities.

As we face continued revenue difficulties for the 2003-05 budget period, the future of the OHP has been in doubt. Earlier in our legislative session, it appeared that we would need to abandon the OHP and return to a traditional Medicaid program, covering only those who are mandatory-eligible and only with mandatory services. But as we have assessed our budget priorities, and in light of the recent federal action to provide fiscal relief to states, we together, as bipartisan legislative leadership and the Governor, have now committed to a restructured Oregon Health Plan.

Although the legislative session has not yet ended and final budget decisions have not been made, we want to outline this commitment to you so that we can begin working expeditiously with your staff to gain the necessary approvals for this restructured program.

Time is of the essence. The longer we must wait to implement a restructured program, the greater the costs of the current program. To that end, our goal is to have the necessary approvals in time to implement a restructured program on October 1, 2003.

Much of the program will remain as outlined under the original OHP waivers and those granted for OHP2, maintaining eligibility for those currently covered, with the following exceptions:

Although expansion of coverage under the FHIAP program will continue, further expansion under the public program will shift from covering adults over the FPL to expanding coverage for children from 185% to 200% of the FPL.

The minimum benefit package for the OHP Standard population will now cover physician services, lab and X-ray, prescription drugs, outpatient mental health and chemical dependency services, limited medical supplies, and emergency dental services.

We are requesting approval to move the line on the 2003-05 prioritized list of health care services recently submitted to the Centers for Medicare and Medicaid Services from line 549 (the equivalent of line 558 on the 2001-03 list) to line 519.

We will either be requesting State Plan approval to reinstate a Medically Needy program or will be requesting a waiver amendment to provide prescription drug coverage for low-income seniors and persons with disabilities who are lacking such coverage through insurance.

Although legislation has not yet been passed, we are pleased that we have been able to reach agreement among our legislative leadership and the Governor to preserve such an important program, even during such difficult economic times. We recognize that a formal waiver amendment request will be required. We will do that as soon as possible after final actions are taken on the OHP budget. In the meantime, we request the assistance of your staff in helping us achieve approval in order to implement changes as of October 1. We know that this is an ambitious timeline, but can only emphasize the importance of immediate implementation so that we can achieve the savings necessary to allow us to preserve the OHP.

Sincerely,

Theodore R. Kulongoski
Governor

Peter Courtney
Senate President

Karen Minnis
House Speaker

Attachment

c: The Honorable Gordon Smith
The Honorable Ron Wyden
The Honorable Earl Blumenauer
The Honorable Peter DeFazio
The Honorable Darlene Hooley
The Honorable Greg Walden
The Honorable David Wu
Tom Scully, CMS Administrator

Appendix B

House Bill 2511 Enrolled

72nd OREGON LEGISLATIVE ASSEMBLY--2003 Regular Session

Enrolled
House Bill 2511

Sponsored by Representative KRUSE; Senator WINTERS

CHAPTER ....

AN ACT

Relating to Department of Human Services; creating new provisions; amending ORS 414.705, 414.720, 414.725 and 414.839 and section 3, chapter , Oregon Laws 2003 (Enrolled House Bill 2160); repealing ORS 414.821, 414.823, 414.827, 414.829, 414.833, 414.834, 414.835 and 414.837; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 414.705 is amended to read:

414.705. **(1)** As used in ORS 414.705 to 414.750, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:

[*(1) Provider services and supplies;*]

[*(2) Outpatient services;*]

[*(3) Inpatient hospital services; and*]

[*(4) Health promotion and disease prevention services.*]

(a) Services required by federal law to be included in the state∍s medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner∍s practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state∍s medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(2) Health services approved and funded under subsection (1) of this section are subject to the prioritized list of health services required in ORS 414.720.

SECTION 2. Sections 3, 4, 4a and 11 of this 2003 Act are added to and made a part of ORS 414.705 to 414.750.

SECTION 3. The Legislative Assembly shall approve and fund health services to the following persons:

(1) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o);

(2) Pregnant women with incomes no more than 185 percent of the federal poverty guidelines;

(3) Persons under 19 years of age with incomes no more than 200 percent of the federal poverty guidelines;

(4) Persons described in section 11 of this 2003 Act; and

(5) Persons 19 years of age or older with incomes no more than 100 percent of the federal poverty guidelines who do not have federal Medicare coverage.

SECTION 4. (1) Subject to funds available:

(a) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under section 3 of this 2003 Act, are eligible to receive all the health services approved and funded by the Legislative Assembly.

(b) Persons described in section 11 of this 2003 Act are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g).

(c) Persons 19 years of age and older who are eligible to receive health services under section 3 of this 2003 Act are eligible to receive the health services described in ORS 414.705
(1)(b) to (m).

(2) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under section 3 of this 2003 Act, must be provided, at a minimum, the health services described in ORS 414.705 (1)(a) to (g).

(3) Persons 19 years of age and older who are eligible to receive health services under section 3 of this 2003 Act must be provided, at a minimum, health services described in ORS 414.705 (1)(b) to (h).

(4) Persons described in section 11 of this 2003 Act must be provided, at a minimum, the health services described in ORS 414.705 (1)(c).

(5) The Department of Human Services shall:

(a) Develop at least three benefit packages of provider services to be offered under ORS 414.705 (1)(j); and

(b) Define by rule the services to be offered under ORS 414.705 (1)(k).

(6) Notwithstanding ORS 414.735, the Legislative Assembly shall adjust health services funded under ORS 414.705 (1) by increasing or reducing benefit packages or health services and, subject to section 4a of this 2003 Act, by increasing or reducing the population of eligible persons.

SECTION 4a. (1) Except as provided in subsection (2) of this section, if insufficient resources are available during a biennium, the population of eligible persons receiving health services may not be reduced below the population of eligible persons approved and funded in the legislatively adopted budget for the Department of Human Services for the biennium.

(2) The Department of Human Services may periodically limit enrollment of persons described in section 11 of this 2003 Act in order to stay within the legislatively adopted budget for the department.

SECTION 4b. If House Bill 2152 does not become law, section 4a of this 2003 Act is amended to read:

Sec. 4a. (1) [*Except as provided in subsection (2) of this section,*] If insufficient resources are available during a biennium, the population of eligible persons receiving health services may [*not*] be reduced below the population of eligible persons approved and funded in the legislatively adopted budget for the Department of Human Services for the biennium.

(2) The Department of Human Services may periodically limit enrollment of persons described in section 11 of this 2003 Act in order to stay within the legislatively adopted budget for the department.

SECTION 5. ORS 414.821, 414.823, 414.827, 414.829, 414.833, 414.834, 414.835 and 414.837 are repealed.

SECTION 6. (1) Except as provided in section 7 of this 2003 Act, sections 3, 4 and 11 of this 2003 Act and the amendments to ORS 414.705 by section 1 of this 2003 Act become operative the day after the date the Department of Human Services is notified by the Centers for Medicare and Medicaid Services that the request by the department to amend the necessary waivers has been approved.

(2) The Director of Human Services shall notify the Legislative Counsel upon receipt of the approval or disapproval of the request to amend the necessary waivers.

SECTION 7. The Director of Human Services may take any action before the operative date of sections 3, 4 and 11 of this 2003 Act and the amendments to ORS 414.705 by section 1 of this 2003 Act that is necessary to enable the director to exercise, on and after the operative date of sections 3, 4 and 11 of this 2003 Act and the amendments to ORS 414.705 by section 1 this 2003 Act, all the duties, functions and powers conferred on the director by sections 3, 4 and 11 of this 2003 Act and the amendments to ORS 414.705 by section 1 of this 2003 Act.

SECTION 8. For the biennium beginning July 1, 2003, the health services provided to persons currently receiving services under ORS 414.705 to 414.750 shall be the services provided on June 30, 2003, until sections 3, 4 and 11 of this 2003 Act and the amendments to ORS 414.705 by section 1 of this 2003 Act become operative.

SECTION 9. ORS 414.839, as amended by section 7, chapter , Oregon Laws 2003 (Enrolled House Bill 2189), is amended to read:

414.839. (1) Subject to funds available, the Department of Human Services may provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals based on incomes up to 200 percent of the federal poverty level. The objective is to create a transition from dependence on public programs to privately financed health insurance.

(2) Public subsidies shall apply only to health benefit plans that meet or exceed the basic benchmark health benefit plan or plans established under section 11**, chapter , Oregon Laws 2003 (Enrolled House Bill 2189)** [*of this 2003 Act*].

(3) Cost-sharing shall be permitted and structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services.

(4) Cost-sharing shall be based on an individual∍s ability to pay and may not exceed the cost of purchasing a plan [*approved as provided under subsection (2) of this section*].

(5) The state may pay a portion of the cost of the subsidy, based on the individual∍s income and other resources.

SECTION 10. ORS 414.720 is amended to read:

414.720. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates [*for*] **representing** seniors[*;*]**,** [*handicapped*] persons[*;*] **with disabilities,** mental health services consumers[*;*] **and** low-income Oregonians[*;*] and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services[*, including health care services of the aged, blind and disabled pursuant to section 14, chapter 753, Oregon Laws 1991, including one list into which those mental health and chemical dependency services recommended pursuant to ORS 414.730 are integrated,*] ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. [*The report shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services. Until federal waiver approval is obtained and funding authorized for the integrated list including mental health and chemical dependence services, the coverage for mental health and chemical dependency services shall not be considered to be mandated.*] The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission may include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(5) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.

(6) The commission may alter the list during interim only under the following conditions:

(a)Technical changes due to errors and omissions; and

(b) Changes due to advancements in medical technology or new data regarding health outcomes.

(7) If a service is deleted or added and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission must report to the Emergency Board to request the funding.

(8) The report listing services to be provided pursuant to ORS 414.036, 414.042, 414.065, 414.107, 414.705 to 414.725 and 414.735 to 414.750 shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year.

<u>SECTION 11</u>. (1) A person is eligible to receive the health services described in section 4 (1)(b) of this 2003 Act when the person is a resident of this state who:

(a) Is 65 years of age or older, is a blind person as defined in ORS 412.005 or is a person who is disabled as defined in ORS 412.510;

(b) Has a gross annual income that does not exceed the standard established by the Department of Human Services; and

(c) Is not covered under any public or private prescription drug benefit program.

(2) A person receiving prescription drug services under section 4 (1)(b) of this 2003 Act shall pay up to a percentage of the Medicaid price of the prescription drug established by the department by rule and the dispensing fee.

<u>SECTION 12.</u> If House Bill 2160 becomes law, section 3, chapter ______ , Oregon Laws 2003 (Enrolled House Bill 2160), is amended to read:

Sec. 3. (1) The Family Health Insurance Assistance Program shall provide coverage of ageappropriate immunizations or other health care services when an eligible individual is enrolled in a health benefit plan that does not provide coverage of age-appropriate immunizations or other health care services required by the [*waiver program described in ORS 414.829*] **state medical assistance program** and the eligible individual is receiving a subsidy described in ORS 414.839.

(2) The Insurance Pool Governing Board shall adopt rules implementing subsection (1) of this section.

<u>SECTION 13.</u> ORS 414.725 is amended to read:

414.725. [*Upon meeting the requirements of section 9, chapter 836, Oregon Laws 1989:*]

(1) Pursuant to rules adopted by the Department of Human Services, the department shall execute prepaid managed care health services contracts for [*the*] health services [*funded pursuant to section 9, chapter 836, Oregon Laws 1989*] **funded by the Legislative Assembly**. The contract must require that all services are provided to the extent and scope of the Health Services Commission∍s report for each service provided under the contract. Such contracts are not subject to ORS 279.011 to 279.063. It is the intent of ORS 414.705 to 414.750 that the state move toward utilizing full service managed care health service providers for providing health services under ORS 414.705 to 414.750. The department shall solicit qualified providers or plans to be reimbursed [*at rates which cover the costs of providing*] **for providing** the covered services. Such contracts may be with

hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private entities. The department [*shall*] **may** not discriminate against any contractors which offer services within their providers∍ lawful scopes of practice. (2) In the event that there is an insufficient number of qualified entities to provide for prepaid managed health services contracts in certain areas of the state, the department may institute a fee-for-service case management system where possible or may continue a fee-for-service payment system for those areas that pay for the same services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750. In addition, the department may make other special arrangements as necessary to increase the interest of providers in participation in the state∍s managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the department for health services provided pursuant to ORS 414.705 to 414.750 [*shall*] **may** not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and [*shall*] **may** not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

SECTION 14. The amendments to ORS 414.725 by section 13 of this 2003 Act apply to prepaid managed care health services contracts entered into on or after the effective date of this 2003 Act.

SECTION 15. Section 16 of this 2003 Act is added to and made a part of ORS 414.705 to 414.750.

SECTION 16. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services as follows:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept payment for hospital services as follows:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(4) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 316.143.

(5) The Department of Human Services shall adopt rules to implement and administer this section.

SECTION 17. This 2003 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2003 Act takes effect on its passage.

Passed by House August 23, 2003

Repassed by House August 27, 2003

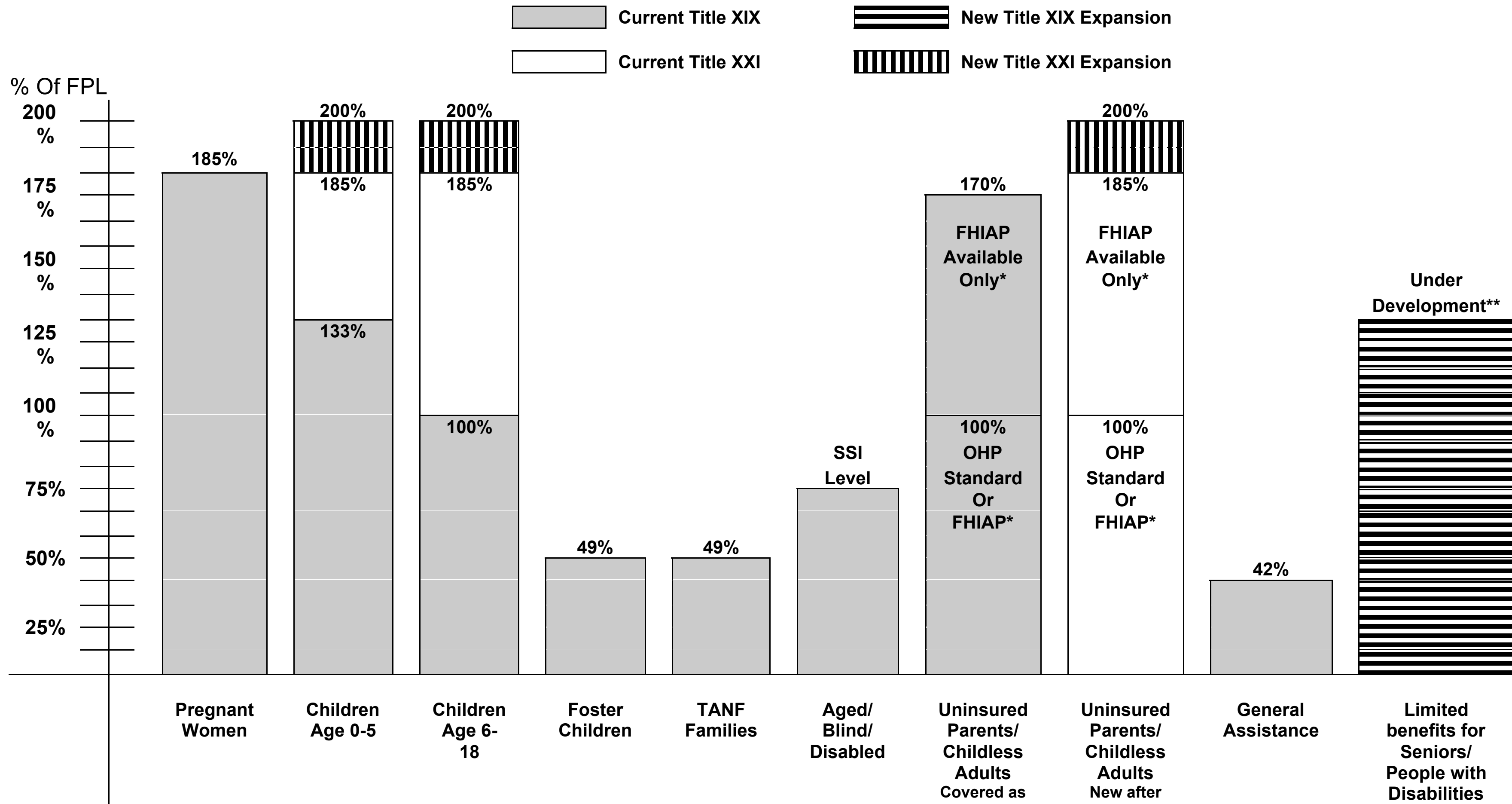
Passed by Senate August 26, 2003

Signed by the Governor, President of Senate and Speaker of the House, August 29, 2003

Appendix C

Overview of Coverage Levels for Current and New OHP Populations

Oregon Health Plan
HIFA/Section 1115 Waiver Amendment Request
Appendix C
Overview of Coverage Levels for Current and New OHP Populations



*The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of FPL must enroll in FHIAP if they have access to employer- sponsored insurance. Parents and childless adults over 100% FPL are not eligible for OHP Standard direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

** See Amendment #4 for a discussion of this proposed new expansion to seniors and persons with disabilities. The state is currently seeking public comment on development of this expansion.

Appendix D

Overview of OHP Populations Affected by Amendment Requests

Oregon Health Plan
HIFA/Section 1115 Waiver Amendment Request
Appendix D
Overview of OHP Populations Affected by Amendment Requests

	Population Overview				Populations Affected by Amendments			
OHP Populations	**Current Eligibility FPL**	**New/ Proposed Eligibility FPL**	**Federal Funding**	**Benefit Package**	**Amend. #1** Prioritized List Line Movement*	**Amend. #2** Redefinition of OHP Standard benefit package	**Amend. #3.** Flexibility with OHP Plus adult benefit package	**Amend. #4** Limited Expansion for seniors & people with disabilities**
Pregnant women	185%		Title XIX	OHP Plus	**X**			
Children Age 0-18	185%	200%	Title XIX & Title XXI	OHP Plus	**X**			
Foster Children	49%		Title XIX	OHP Plus	**X**			
TANF Families	49%		Title XIX	OHP Plus	**X**		**X**	
Aged/Blind/Disabled	SSI Level		Title XIX	OHP Plus	**X**		**X**	
Uninsured Parents/Childless Adults	100%		Title XIX & Title XXI	OHP Standard	**X**	**X**		
FHIAP*	185%	200%	Title XIX & Title XXI	FHIAP				
General Assistance	42%		Title XIX	OHP Plus	**X**		**X**	
Senior/Disabled Limited Benefit Expansion		Under development	Title XIX	OHP MEDS (Pharmacy)	**X**			**X**

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