Application Template for Health Insurance Flexibility and Accountability (HIFA)/1115 Demonstration Proposal

The State of Oregon, Department of Human Services proposes a section 1115 demonstration entitled The Oregon Health Plan 2 (OHP2), which will increase the number of individuals with health insurance coverage.

I. General Description of Program

The OHP2, which is scheduled to begin on October 1, 2002, will provide health insurance coverage to an additional 46,000 residents of the State of Oregon with incomes up to 185 percent of the Federal poverty level. The increased coverage will be funded by Oregon's SCHIP allotment and any reallocated funds. However, since the State anticipates that expenditures may exceed the allotment, Oregon is requesting authority to receive Medicaid match for some or all of these individuals under an amendment to its current Section 1115 waiver for the Oregon Health Plan (OHP).

II. Definitions

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments.)

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA Demonstration Standard Features

Please place a check mark beside each feature to acknowledge agreement with the standard features.

- ✓ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply. (**Note: CMS has not provided these**)
- ✓ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.
- ✓ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.
- ✓ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.
- ✓ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.
- ✓ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

IV. State Specific Elements

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is 185 percent of the FPL.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations (as specified in Title XIX.)

_____ Section 1931 Families

_____ Blind and Disabled

_____ Aged

_____ Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

____ Children and pregnant women covered in Medicaid above the mandatory level

____ Parents covered under Medicaid

____ Children covered under SCHIP

____ Parents covered under SCHIP

____ Other (please specify)

Medically Needy

____ TANF Related

____ Blind and Disabled

____ Aged

____ *Title XXI children (Separate SCHIP Program)*

____ *Title XXI parents (Separate SCHIP Program)*

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.)

Populations that can be covered under a Medicaid or SCHIP State Plan

__✓__ Children above the income level specified in the State Plan
This category will include children from 170 percent of the FPL up to 185 percent of the FPL.

____ Pregnant women above the income level specified in the State Plan
This category will include individuals from ___ percent of the FPL through percent of the FPL.

__✓__ Parents above the current level specified in the State Plan
This category will include individuals from 100 percent of the FPL up to 185 percent of the FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

____ Childless Adults (This category will include individuals from _____ percent of the FPL through _____ percent of the FPL.)

____ Pregnant Women in SCHIP (This category will include individuals from _____ percent of the FPL through _____ percent of the FPL.)

____ Other. Please specify: _____
_____
_____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the new HIFA demonstration.

__✓__ Childless Adults (This category will include individuals from 100 percent of the FPL up to 185 percent of the FPL.)

____ Pregnant Women in SCHIP (This category will include individuals from _____ percent of the FPL through _____ percent of the FPL.)

____ Other. Please specify: _____
_____
_____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

_____ No

__✓__ Yes

(If Yes) Number of participants
or dollar limit of demonstration The expenditure cap is the SCHIP allotment plus reallocated funds minus the amount spent on SCHIP children. Any individual excluded from this demonstration as a result of the cap may receive coverage through the proposed amendment to the State's current Section 1115 demonstration for OHP, which will provide the same benefits through the same delivery system as this demonstration. The funding priority is SCHIP children, expansion FHIAP populations, then the OHP Standard expansion populations.
(Express dollar limit in terms of total computable program costs.)

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased in.

____ The HIFA demonstration will be implemented at once.

__✓__ The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline): OHP Standard enrollment will be expanded initially up to 110% of FPL, then moved up by 15% income bands as budget allows, giving priority to parents of SCHIP and PLM children and current clients moving over the upper income limit of OHP Standard. FHIAP will expand by about 9,500 in group insurance initially then will open individual insurance. After that time, enrollment in individual insurance will be restricted to keep it approximately equal, from a State General Fund perspective, with group expansion.

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

____ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

2. Optional populations included in the existing Medicaid State Plan

____ The same coverage provided under the State's approved Medicaid State plan.

____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees

____ A benefit package that is actuarially equivalent to one of those listed above

____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

_____ The same coverage provided under the State's approved Medicaid State plan.

_____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State

_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

_____ A health benefits coverage plan that is offered and generally available to State employees

_____ A benefit package that is actuarially equivalent to one of those listed above

_____ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

____ The same coverage provided under the State's approved Medicaid State plan.

____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees

____ A benefit package that is actuarially equivalent to one of those listed above

__✓__ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations — States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general

practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included.

___✓___ Inpatient

___✓___ Outpatient

___✓___ Physician's Surgical and Medical Services

___✓___ Laboratory and X-ray Services

___✓___ Pharmacy

___✓___ Other (please specify) See Attachment C

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	**Fee-For-Service**	**Medicaid or SCHIP Managed Care**	**Private health insurance coverage**	**Group health plan coverage**	**Other (specify)**
Mandatory					
Optional – Existing					
Optional – Expansion	✓	✓	✓	✓	
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP					
Existing section 1115 expansion					
New HIFA Expansion	✓	✓	✓	✓	

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

✓ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

____ The same coverage provided under the State's approved Medicaid plan.

____ The same coverage provided under the State's approved SCHIP plan.

____ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees.

____ A benefit package that is actuarially equivalent to one of those listed above (please specify).

____ Secretary-Approved coverage.

___✓ Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)

✓ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

✓ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory			
Optional – Existing (Children)			
Optional – Existing (Adults)			
Optional – Expansion (Children)			
Optional - Expansion (Adults)			✓
Title XXI – Medicaid Expansion			
Title XXI – Separate SCHIP			
Existing section 1115 Expansion			
New HIFA Expansion			✓

Cost-sharing for children

Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as 'child cost-sharing' for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State as of 2000 for individuals below 185 percent of poverty.

22.6%

The coverage rates in your State for the insurance categories for individuals below 185 percent of poverty:

Private Health Insurance Coverage Under a Group Health Plan	34.2%
Other Private Health Insurance Coverage	8.3%
Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)	22.5% (section 1906 enrollment not available from the State survey)
SCHIP (please separately identify any premium assistance)	Not available from the State survey
Medicare	24.7%
Other Insurance	10.3%

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

____ The Current Population Survey

____ Other National Survey (please specify_____)

__✓__ State Survey (please specify) Oregon Population Survey 2000; See Attachment F

____ Administrative records (please specify_____)

____ Other (please specify_____)

Adjustments were made to the Current Population Survey or another national survey.

____ Yes ____ No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

__✓__ Yes ____ No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

Oregon's goal is to reduce the uninsured rate for individuals with income up to 185% FPL by 1%.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

✓ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. Program Costs

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be $154 million over its five (5) year approval period.

VII. Waivers and Expenditure Authority Requested

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable):

Title XIX:

____ **Statewideness 1902(a)(1)**

To enable the State to phase in the operation of the demonstration.

____ **Amount, Duration, and Scope 1902(a)(10)(B)**

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

____ **Freedom of Choice 1902(a)(23)**

To enable the State to restrict the choice of provider.

Title XXI:

__✓__ **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

__✓__ **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

_____ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

____ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

___✓ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

___✓ Expenditures related to providing six months of guaranteed eligibility to OHP Standard demonstration participants and twelve months of guaranteed eligibility to FHIAP enrollees.

___✓ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

____ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

___✓ Attachment B: Detailed description of expansion populations included in the demonstration.

___✓ Attachment C: Benefit package description.

___✓ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

___✓ Attachment E: Detailed discussion of cost sharing limits.

___✓ Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

___✓ Attachment G: Budget worksheets.

___✓ Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

_____ _____

Date Name of Authorizing State Official (Typed)

_____

Signature of Authorizing State Official

Attachment B — Populations Included in the Demonstration

The following eligibility groups will be at least initially funded through this demonstration using Title XXI funds:

Eligibility Category	Income Criteria
SCHIP Children	170% up to 185% FPL
Parents	100% up to 185% FPL
Adults/Couples	100% up to 185% FPL
FHIAP Families (Expansion)	0% up to 185% FPL
FHIAP Adults/Couples(Expansion)	0% up to 185% FPL

The asset limit for OHP Standard (which includes parents and adults/couples without qualified employer-sponsored insurance available) will be $2,000 (the current limit for Medicaid adults), with no assets limit for Medicaid children. The asset limit for SCHIP children will continue to be $5,000. The asset limit for FHIAP will be $10,000. Note that the asset test will be tied to the program and not the funding source. For example, although FHIAP will be funded in part by SCHIP and Title XIX dollars, the asset test will be $10,000, not $5,000.

Attachment C — Benefit Package Description

OHP2 will maintain the current Oregon Medicaid/SCHIP benefit package for certain populations (referred to as OHP Plus), add a second reduced benefit package — OHP Standard — for other populations, and subsidize private insurance for people eligible for OHP2 and who have qualified employer-sponsored insurance (ESI) available to them or, if ESI is not available, individual coverage (this is referred to as FHIAP).

OHP Plus

OHP Plus will be provided to people eligible for Medicaid (without a waiver), General Assistance recipients, and pregnant women and children (both Medicaid and SCHIP) up to 185 percent FPL. (Note: children with family income from 170 percent of FPL up to 185 percent of FPL will be funded through this HIFA waiver.) Under OHP2 the Health Services Commission will continue to maintain its Prioritized List of Health Care Services, using it to establish the OHP Plus benefit package of health care services. Coverage is currently provided through line 566 on this list. It is anticipated that any change in benefits in OHP Plus would be through a public process and would need to be approved by the Legislature or the Legislative Emergency Board. Oregon requests that as part of the terms and conditions, CMS and Oregon establish a streamlined process through which Oregon can move the coverage line further up or down the list.

OHP Standard

OHP Standard will provide basic coverage more similar to private insurance coverage. The initial benefit package, which includes premium sharing and copayments (See Attachment E), has been designed to provide benefits at least actuarially equivalent to the federally mandated Medicaid benefit package. The initial OHP Standard benefit level is equivalent to approximately 78 percent of the value of the OHP Plus benefit package (including a portion of the additional premiums). The groups that may receive OHP Standard include those optional and expansion populations not included in OHP Plus that do not have qualified employer-sponsored insurance (ESI) available. These groups include:

- Parents and Adults/Couples below 100 percent FPL made eligible through the OHP waiver (this population will continue to be funded through Title XIX and is not part of the HIFA demonstration); and
- Parents and Adults/Couples below 185 percent FPL made eligible through OHP2 (this population is included in the HIFA demonstration).

Cost-sharing and benefit reductions in OHP Standard are overlaid on the Prioritized List of Healthcare Services. Services excluded from OHP Plus coverage because they are “below the line” will also be excluded from OHP Standard coverage.

As initially funded, the following benefits will be included in OHP Standard:

- Inpatient hospital
- Outpatient hospital
- Emergency room
- Physician services
- Lab and X-ray
- Ambulance
- Prescription drugs
- Mental health and chemical dependency
- Durable medical equipment (needed on an ongoing, not one-time, basis)
- Dental

The following benefits will not be included in OHP Standard:

- Vision
- Non-emergency transportation

OHP Standard benefits appear in an order that reflects the value placed on the services as indicated through the community forums, stakeholder meetings, and the Health Services Commission's (HSC) judgment as to the priority in a benefit package designed to promote access to care. It is anticipated that any change in benefits for OHP Standard would be through a public process and would need to be approved by the Legislature or the Legislative Emergency Board. The HSC will do additional work on further benefit approaches to allow ongoing flexibility of the benefit package so it can be adjusted to available revenue as necessary.

Oregon is requesting the ability to adjust OHP Standard benefits as necessary to continue coverage when revenue constraints tighten. Specifically, Oregon is seeking permission to adjust the OHP Standard benefit level as long as this benefit level is at least actuarially equivalent to the federally mandated Medicaid benefit package. That level is equivalent to approximately 56 percent of the value of the current OHP Plus benefits. The OHP Standard benefits described above are the initial benefits as recommended for program implementation. In subsequent biennia, Oregon will set the OHP Standard benefits at a level that can be supported by available revenue, and OHP Standard benefits will always be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

See Attachment D for a description of the FHIAP benefit package and cost-sharing.

See Attachment E for a discussion of cost-sharing for OHP Plus and OHP Standard.

Attachment D — Detailed Description of Private Health Insurance Coverage Options

Overview

Under this demonstration Oregon proposes to provide premium subsidies for the purchase of private health insurance for uninsured Oregonians with incomes up to 185 percent of the federal poverty level (FPL) through the existing Family Health Insurance Assistance Program (FHIAP).

FHIAP is a State-funded subsidy program to help low-income people afford private group or individual health care coverage. FHIAP currently provides a premium subsidy that individuals and families with income up to 170 percent FPL can use to access their employer-sponsored insurance (ESI), including portability, state continuation, and COBRA. When ESI is unavailable, FHIAP offers premium assistance to purchase individual policies, including Oregon Medical Insurance Pool (OMIP) coverage. FHIAP is administered by the Insurance Pool Governing Board (IPGB). FHIAP was implemented in 1998 and currently has approximately 4,000 enrollees and 22,000 people on its reservation lists.

FHIAP Benchmark

The Insurance Pool Governing Board (IPGB), in consultation with the Health Insurance Reform Advisory Committee (HIRAC), is statutorily charged with establishing a group benchmark for subsidized ESI coverage to be used as a tool for evaluating private-sector health insurance. In effect, the benchmark identifies a minimum level of benefits qualifying for FHIAP subsidy — it does not define a benefit plan to be offered to enrollees.

Based on an evaluation of the benefits and cost-sharing provisions common in Oregon's small group health insurance market, the IPGB established a group benchmark that includes:

- A six-month pre-existing condition waiting period,
- 20 benefit categories
- The following maximum cost-sharing levels:
  - $500 annual individual deductible;
  - $2,500 maximum out-of-pocket per individual or $10,000 stop-loss; and
  - $1,000,000 lifetime maximum benefit.

In addition, since prescription drug benefits are generally purchased separately from medical coverage as an optional benefit, the IPGB established a prescription drug cost-sharing level of 25 percent with no out-of-pocket maximum.

FHIAP group coverage will include persons who have qualified employer-sponsored insurance (ESI) available, including portability, State continuation, and COBRA. An ESI plan will qualify if it meets or exceeds the FHIAP group benchmark. The IPGB and their actuaries are developing a tool to evaluate benefit plans against the group benchmark. This evaluation tool will be used when a sub-

mitted group plan fails on initial examination to meet or exceed the benchmarks. With the tool, IPGB can determine if the overall relative value of the submitted plan meets or exceeds the value of the benchmark. ESI is considered available if it is offered by the employer to the employee, and the employer contributes appropriately to the cost of coverage.

Insurance subsidies will also be available for individual health insurance policies in specific circumstances and will include a cost-effectiveness test. Individuals and families accepted into FHIAP individual coverage may only purchase health insurance from FHIAP-certified carriers. There are currently seven certified carriers for FHIAP individual coverage.

The IPGB has adopted a benchmark for the individual market; it is identical to the group benchmark. Note that like other states, Oregon mandates that certain services be covered in private health insurance policies. A description of the current Oregon mandates is included in Appendix 3.2 to the Section 1115 amendment application.

Oregon is requesting the ability to adjust the FHIAP benefit benchmark as necessary to continue to subsidize benefit coverage commonly found in Oregon's small employer health insurance market, as directed to in House Bill 2519. Specifically, Oregon is seeking permission to adjust the FHIAP benefit benchmark as long as this benchmark is at least actuarially equivalent to the federally mandated Medicaid benefit package. The FHIAP benefit benchmark described below is the initial benchmark recommended for program implementation. The IPGB may annually survey Oregon's small group health insurance market to determine the most common benefits and cost-sharing levels, and may adjust the benchmark accordingly. The FHIAP benefit benchmark will always be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

A complete list of the benefits and cost-sharing levels for the FHIAP benchmark for group health insurance plans are presented on the following page:

FHIAP Benchmark for Group Health Insurance Plans	
Pre-existing Condition Waiting Period	6 Month
Annual Deductible	$500 individual
Maximum Out-of-pocket or Stop Loss	$2,500 individual or $10,000 individual
Lifetime Maximum	$1,000,000
Prescription Drugs	25% enrollee cost-sharing
Prescription Drug Maximum Out-of-pocket	No out-of-pocket maximum
Doctor Visits	Covered Benefit*
Immunization	Covered Benefit*
Well Baby Care	Covered Benefit*
Well Child Care	Covered Benefit*
Women's Health Care Services	Covered Benefit*
Maternity	Covered Benefit*
Diagnostic X-Ray/Lab	Covered Benefit*
Hospital	Covered Benefit*
Outpatient Surgery	Covered Benefit*
Emergency Room	Covered Benefit*
Ambulance	Covered Benefit*
Transplant	Covered Benefit*
Mental Health/Chemical Dependency Outpatient	Covered Benefit*
Mental Health/Chemical Dependency Inpatient	Covered Benefit*
Skilled Nursing Care	Covered Benefit*
Durable Medical Equipment	Covered Benefit*
Rehabilitation Inpatient	Covered Benefit*
Rehabilitation Outpatient	Covered Benefit*
Hospice	Covered Benefit*
Home Health	Covered Benefit*

**Covered benefit means services are offered in a benefit category. Benchmark does not specify durational, internal, or cost-sharing limits beyond those imposed by the annual deductible, maximum out-of-pocket, stop loss, and lifetime maximums.*

FHIAP Subsidy

The current FHIAP subsidy levels are based on a family's average monthly gross income and are a percentage of premium cost after any applicable employer contribution. The anticipated FHIAP subsidy levels under OHP2 are as follows:

Percentage of FPL	Subsidy Level
0% up to 125% FPL	95% subsidy
125% up to 150% FPL	90% subsidy
150% up to 170% FPL	70% subsidy
170% up to 185% FPL	50% subsidy

People enrolled in an employer's plan will be reimbursed for the premium withheld from their paychecks (minus the enrollee's share of the premium), provided the enrollee submits verification that the premium is being withheld. Copies of paycheck stubs will serve as verification. After a written warning, failure to provide verification will result in termination from the program.

Enrollees in the individual market will be billed by FHIAP each month for their portion of the premium. The State will then combine the enrollee's portion with the subsidy and pay the carrier. As with OHP Standard enrollees, FHIAP enrollees who fail to pay their premium will be disenrolled. Also as with OHP Standard, people who want to re-enroll in the program after being disenrolled for failure to pay premiums will be subject to a period of uninsurance up to six months and any applicable waiting period.

Monitoring Plan

Oregon will monitor costs for enrollees in FHIAP to ensure that costs are not higher than costs would be for coverage in the direct coverage program. The State will also monitor changes in employer contribution levels and make modifications in FHIAP if necessary.

FHIAP currently collects, and reports weekly, the following information regarding costs to the FHIAP program (on a per life basis):

- **Premium Costs (member share and State subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
- **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
- **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
- **Employer Contributions:** By subsidy level, with a weighted overall average.
- **Overall Premium Cost:** For individual and group, with a weighted overall average.
- **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

In order to measure costs, the State will compare the overall weighted average subsidy cost (which is reported on a per member per month basis) to the per member per month cost of the OHP Standard benefit package. This would be done on a quarterly basis.

The State will develop reports that show the employer contribution by subsidy level, both in terms of total dollars and percentage of premium. In addition, FHIAP will report historical levels of employer contributions, as total dollars and percentage of premium, on a monthly or quarterly basis. These reports could be used by the State to determine if the employer contribution levels were declining, and if so, what steps could be taken to stop or reverse the decline. Options include requiring (or raising) a minimum dollar contribution or minimum premium percentage contribution from the employer towards individual or family coverage before an employer plan could be subsidized by FHIAP.

While these historical reports reflect the experience of FHIAP, comparing the FHIAP levels to the experience of the regular health insurance market may help the State determine if the premium assistance program is having a negative effect on employer contributions. This could be accomplished by working with major domestic carriers to collect information on employer contribution levels. This would need to be done on a voluntary basis, since the State currently doesn't collect this information and may not have statutory authority to require it.

Monitoring Quality

Since private insurance plans do not contract with the State, the State cannot require the plans to meet Medicaid requirements or produce encounter data or other reports. Of necessity, then, the monitoring approach must be different. The State will rely on the enrollment and disenrollment information (period of time the coverage was purchased, reason for termination such as loss of employment or dissatisfaction with coverage) contained in the FHIAP data system and client satisfaction surveys (e.g., CAHPS). The FHIAP application and data system will also allow the State to monitor the demographics of those participating in the program, the cost of coverage purchased, and the percentage of income required for premium contributions.

Attachment E — Detailed Discussion of Cost-Sharing

OHP Plus

Oregon has filed a State plan amendment to permit minimal copayments on medications and outpatient services. The copayments on medications will be $2 for generic drugs and $3 for brand-name drugs. There will also be a $3 copayment for outpatient services. In compliance with 42 CFR 447.53(b), individuals through age 18, pregnant women, institutionalized individuals, emergency services, family planning services and supplies, and services provided by health plans will be exempt from copayment requirements. Copayments will be collected by providers. OHP Plus enrollees who indicate to the provider that they cannot pay the copayment at the time the service is provided cannot be refused services because of their inability to pay. However, enrollees are liable for the copayment and are expected to pay the copayment when they are able to do so.

There will be no premiums for OHP Plus enrollees.

OHP Standard

The first six benefits (through Ambulance — see list in Attachment C) of the OHP Standard package are Medicaid mandatory services. These six services, with no cost-sharing, account for 56 percent of the actuarial value of the current OHP package (the OHP Plus package under OHP2). In order to add optional services such as prescription drugs and achieve a benefit package that was comparable to the packages available in the private health insurance market, cost-sharing was added to the mandated services as well as the optional services included in the package. Cost-sharing for OHP Standard will include copayments and premiums.

Anticipated copayments in the initial benefit package (at 78 percent of the value of OHP Plus) will be as follows:

Service	Copayment
Inpatient Hospital	$250 copayment per admission
Outpatient Hospital	• $20 copayment/surgery • $5 copayment for other outpatient services
Emergency Room	$50 copayment, waived if admitted
Physician Services	• $5 copayment for office visits • $3 to $10 copayment for medical & surgical procedures
Lab and X-ray	$3 copayment for each lab and X-ray
Ambulance	$50 copayment
Prescription Drugs	0% up to 100% FPL • $2 generic • $3 MH/cancer/ HIV brand drugs • $15 other brand 100% up to 185% FPL • $5 generic • $10 MH/cancer/ HIV brand drugs • $25 other brand
Mental Health and Chemical Dependency	• $5 copayment • No copayment on dosing/dispensing or case management services
Durable Medical Equipment	• Recurrent: $2 copayment per 30 days • No coverage for one-time DME
Dental	• Preventive and Dx: zero/minimum copayments (See Appendix 3.1 of Section 1115 amendment proposal) • Restorative: graduated copayments (See Appendix 3.1 of Section 1115 amendment proposal) • $500 benefit limit

In keeping with the objectives of OHP and OHP2 to provide access to care at the appropriate time, copayments will not be required for the following preventive services:

- Pap smears
- Mammograms
- Women's annual health exams
- Fecal occult blood tests/Diagnostic sigmoidoscopy (over age 50)
- Total blood cholesterol screenings (men age 35-64, women age 45-64)
- Preventive dental exams
- Rubella serology or vaccinations (women of childbearing age)
- Tetanus diphtheria (Td) boosters

- Age-appropriate Influenza immunizations
- Age-appropriate Pneumococcal vaccinations

Except as noted above, copayments will be required of all OHP Standard enrollees. Providers will be responsible for collecting copayments. However, unlike in OHP Plus, providers may refuse to provide a service (other than emergency services) if the copayment is not paid.

The anticipated premium structure for OHP Standard will be as follows:

Percent FPL	Per Person	Premium Share
0% up to 10% FPL	$6.00	2.4%
10% up to 50% FPL	$9.00	3.6%
50% up to 65% FPL	$15.00	6%
65% up to 85% FPL	$18.00	7.2%
85% up to 100% FPL	$20.00	8%
100% up to 125% FPL	$23.00[1]	9.2%
125% up to 150% FPL	$35.00[1]	14%
150% up to 170% FPL	$75.00[1]	30%
170% up to 185% FPL	$125.00[1]	50%

[1]Premiums for people with income above 100 percent up to 185 percent FPL will be based on percentage of the OHP Standard benefit package, not fixed at these dollar amounts.

As is currently done for OHP, the State will collect premiums. Unlike in OHP, persons in OHP Standard who fail to pay their premiums will be disenrolled after receiving adequate notice. People who want to come back into the program after having been disenrolled will be subject to a period of uninsurance of up to six months and any applicable waiting period.

Attachment F — Additional Detail Regarding Measuring Progress Toward Reducing the Rate of Uninsurance

Information on State Survey

Every two years since 1990, the Oregon Population Survey is conducted. The 2000 Oregon Population Survey was conducted during the spring and summer of 2000. The 2000 survey was conducted by Bardsley & Neidhart Inc., an impartial research and consulting firm based in Portland, Oregon.

Questionnaire Design

Questionnaire design was a joint effort between a State Task Force and Bardsley & Neidhart Inc. Every attempt was made to keep questions consistent with those asked in previous Population Surveys, and with the upcoming 2000 Census. The base and questionnaire was pre-tested in all sectors of the state. Results of the pre-tests were reviewed with the Task Force and questionnaire revisions were made as needed.

Survey Administration

All facets of the project were conducted in-house by Bardsley & Neidhart Inc. Interviewing was completed using their CATI (Computer Assisted Telephone Interviewing) system, which allows for a great degree of quality control and minimizes data entry error.

All questions, coding and skip logic were programmed into the CATI system and pretested before fielding began. The CATI system prevents input of any data beyond the coded bounds and allows for constant testing for inconsistencies in the data. Continuous monitoring by trained supervisors ensured that all surveys were completed completely and correctly.

Sampling

In the base survey, a total of 3,633 Oregon households were interviewed. A target of at least 400 interviews was created in each of nine regions. The number of interviews per county was determined by ascertaining the proportion of that county's population as compared to the population of the entire region. All Oregon counties were included in the sample. Additionally, sample extensions were conducted to increase sample sizes for members of four ethnic/racial groups: African-Americans, Asian-Americans, Native Americans and Hispanics. The sample provides a maximum sampling variability of ±1.6% at the 95% confidence level for the statewide sample.

Respondent Selection

The statewide sample was derived using a random digit sample purchased from Strategic Sampling Inc. This method ensures that the sample is representative of the entire "telephone household" population, including those with new and unlisted numbers, not just those who are listed in telephone directories.

Data was collected from their in-house telephone facility in Portland. All phases of the interviewing process were closely supervised and monitored to assure strict adherence to quality control standards and sample quotas.

In the base survey, interviewers followed a rigid system of respondent selection that targeted the member of the household with the most recent birthday. This method is widely accepted in the research community as a method of respondent selection that minimizes selection bias.

Data Processing

Bardsley & Neidhart applied weights based on 2000 Census figures. Data were weighted to cast their proper representation in the universe. Weighting schemes have also been implemented to adjust for the under-representation of single-person households, which is common with telephone surveys. Additionally, weighting has been applied to correctly apply the proportions by regional population, racial groups, ethnic groups and age groups (<65 years old and 65+ years old) in the statewide population.

The Task Force reviewed and approved the data sets and the weighting scheme before they were presented in their final form.

In addition, certain commonly used household-level variables, such as income and poverty, were imputed to all members of the household to allow for person-level analysis of these factors. With these exceptions, no imputation of data was performed.

Monitoring Progress Toward Reducing the Rate of Uninsurance

Oregon will track changes in the uninsured rate and sources of coverage using the Oregon Population Survey.

Monitoring OHP Standard

OHP has in place an established and effective quality improvement system for monitoring access to and quality of care. This monitoring system will remain in place for OHP Standard. The existing components of the OHP quality improvement system that will remain in place include many of the standard measures of quality and access to care as well as special quality improvement (QI) initiatives. The core measures include:

- Quality improvement (QI) evaluations of health plans focused on their QI programs (includes on-site review; plan-submitted documentation of their QI programs etc.; annual to bi-annual reviews);
- External Quality Review Organization (EQRO) that uses chart reviews and encounter/claims data to determine if the quality of care meets clinical practice guidelines. (At the present time, the EQRO that is contracted with OMAP is Permedion);
- Plan-reported complaints (Quarterly submission of complaint reports);
- Disenrollment quarterly reports (State collected "reasons for disenrollment" from health plans);
- State's Client Advocate Services Unit quarterly report (Reasons for calls by plan);
- Enrollment/Eligibility tracking reports (Monthly enrollment numbers; "Churning" in plans);
- Health plan's annual Physician Capacity report;

- Financial statements submitted quarterly by plans (monitor financial solvency);
- MCO submitted annual performance measures (i.e., selected HEDIS measures);
- HEDIS and modified HEDIS measures addressing utilization, access to care, and quality of care from encounter/claims data;
- Ad Hoc studies of access to and quality of health care (Irregular);
- Survey of client satisfaction with access to and quality of care given health status of clients (CAHPS-Consumer Assessment of Health Plans Survey);
- Regular contact with and technical assistance to QI coordinators of health plans such as on-site attendance at plan QI committee meetings etc.;
- Monitoring of data quality, accuracy and completeness (i.e. encounter data monitoring).

In addition to these core features of the OHP quality improvement and monitoring plan, two special initiatives are also in place:

- Statewide QI Projects: Project PREVENTION! is required of all health plans. For example, projects that have been adopted are Immunization ALERT Registry, Tobacco Cessation and Early Childhood Cavities Prevention);

Monitoring access to and quality of care through community partnerships such as Oregon MothersCare (access to prenatal care) and through coordination of mental health and primary care.

Attachment G — Budget Worksheets

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds	Previous Fiscal Year (FFY 2002)	Federal Fiscal Year 1 (FFY 2003)	Federal Fiscal Year 2 (FFY 2004)	Federal Fiscal Year 3 (FFY 2005)	Federal Fiscal Year 4 (FFY 2006)	Federal Fiscal Year 5 (FFY 2007)
State's Allotment	**$37,597,000**	**$37,000,000**	**$37,000,000**	**$37,000,000**	**$37,000,000**	**$37,000,000**
Funds Carried Over From Prior Year(s)	**$94,030,100**	**$87,731,100**	**$74,542,258**	**$55,632,694**	**$31,132,242**	**$481,671**
SUBTOTAL (Allotment + Funds Carried Over)	**$131,627,100**	**$124,731,100**	**$111,542,258**	**$92,632,694**	**$68,132,242**	**$37,481,671**
Reallocated Funds (Redistributed or Retained that are Currently Available)	**$15,260,000**					
TOTAL (Subtotal + Reallocated funds)	**$146,887,100**	**$124,731,100**	**$111,542,258**	**$92,632,694**	**$68,132,242**	**$37,481,671**
State's Enhanced FMAP Rate	**71.76%**	**71.76%**	**71.76%**	**71.76%**	**71.76%**	**71.76%**
COST PROJECTIONS OF APPROVED SCHIP PLAN						
Benefit Costs						
Insurance payments						
Managed care	$14,532,938	$18,598,202	$20,525,411	$22,577,887	$24,835,747	$27,319,251
per member/per month rate @ # of eligibles	90.98	100.08	110.20	121.22	133.34	146.67
Fee for Service	$4,412,360	$5,646,619	$6,231,740	$6,854,895	$7,540,406	$8,294,425
Total Benefit Costs	**$18,945,298**	**$24,244,821**	**$ 26,757,151**	**$29,432,782**	**$32,376,153**	**$35,613,676**
(Offsetting beneficiary cost sharing payments)	$0	$0	$0	$0	$0	$0
Net Benefit Costs	$18,945,298	$24,244,821	$26,757,151	$29,432,782	$32,376,153	$35,613,676
Administration Costs						
Personnel	$252,604	$323,264	$356,762	$392,437	$431,682	$474,849
General administration	$1,052,517	$1,346,935	$1,486,508	$1,635,155	$1,798,675	$1,978,538
Contractors/Brokers (e.g., enrollment contractors)						
Claims Processing	$799,913	$1,023,670	$1,129,746	$1,242,717	$1,366,993	$1,503,689
Outreach/marketing costs						
Other						
Total Administration Costs	$2,105,033	$2,693,869	$2,973,017	$3,270,309	$3,597,350	$3,957,075
10% Administrative Cap	$2,105,033	$2,693,869	$2,973,017	$3,270,309	$3,597,350	$3,957,075
Federal Title XXI Share	$15,105,718	$19,331,204	$21,334,368	$23,467,738	$25,814,586	$28,395,971
State Share	$5,944,614	$7,607,486	$8,395,799	$9,235,353	$10,158,917	$11,174,780
TOTAL COSTS OF APPROVED SCHIP PLAN	$21,050,331	$26,938,690	$29,730,168	$32,703,091	$35,973,503	$39,570,751
COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL						
Benefit Costs for Demonstration Population #1 (OHP Standard Expansion)						
Insurance payments						
Managed care		$13,814,090	$0	$0	$0	$0
per member/per month rate @ # of eligibles		$ 311.32				
Fee for Service		$2,631,255	$0	$0	$0	$0
Total Benefit Costs for Waiver Population #1		$16,445,345	$0	$0	$0	$0
Benefit Costs for Demonstration Population #2 (FHIAP Group Expansion)						
Insurance payments		$15,396,535	$26,358,724	$28,994,596	$31,894,055	$5,613,354
Managed care						
per member/per month rate @ # of eligibles		$ 104.08	$ 112.98	$ 124.28	$ 136.71	$ 150.36
Fee for Service						
Total Benefit Costs for Waiver Population #2		$15,396,535	$26,358,724	$28,994,596	$31,894,055	$5,613,354

Benefit Costs for Demonstration Population #3 (FHIAP Individual Expansion)						
Insurance payments		$7,178,436	$15,416,546	$16,958,200	$18,654,020	$3,283,108
Managed care						
per member/per month rate @ # of eligibles		$ 215.26	$ 231.15	$ 254.26	$ 279.69	$ 307.75
Fee for Service						
Total Benefit Costs for Waiver Population #3		$7,178,436	$15,416,546	$16,958,200	$18,654,020	$3,283,108
Benefit Costs for Demonstration Population #4 (Children)						
Insurance payments						
Managed care		$747,406	$1,218,361	$1,340,198	$1,474,217	$1,621,639
per member/per month rate @ # of eligibles		101.49	110.30	121.33	133.46	146.80
Fee for Service		$226,921	$369,908	$406,899	$447,589	$492,347
Total Benefit Costs for Waiver Population #4		$974,326	$1,588,269	$1,747,096	$1,921,806	$2,113,986
Total Benefit Costs	$0	$39,994,642	$43,363,539	$47,699,892	$52,469,882	$11,010,448
(Offsetting beneficiary cost sharing payments)		$1,437,323	$0	$0	$0	$0
Net Benefit Costs	$0	$38,557,319	$43,363,539	$47,699,892	$52,469,882	$11,010,448
Administration Costs						
Personnel		$533,262	$578,181	$635,999	$699,598	$146,806
General administration		$2,221,925	$2,409,085	$2,649,994	$2,914,993	$611,692
Contractors/Brokers (e.g., enrollment contractors)						
Claims Processing		$1,688,663	$1,830,905	$2,013,995	$2,215,395	$464,886
Outreach/marketing costs						
Other (specify)						
Total Administration Costs		$4,443,849	$4,818,171	$5,299,988	$5,829,987	$1,223,383
10% Administrative Cap		$4,443,849	$4,818,171	$5,299,988	$5,829,987	$1,223,383
Federal Title XXI Share		$30,857,638	$34,575,195	$38,032,714	$41,835,986	$8,778,997
State Share		$12,143,530	$13,606,515	$14,967,166	$16,463,883	$3,454,834
TOTAL COSTS FOR DEMONSTRATION	$0	$43,001,168	$48,181,710	$52,999,881	$58,299,869	$12,233,831
TOTAL PROGRAM COSTS (State Plan + Demonstration)	$21,050,331	$69,939,858	$77,911,877	$85,702,972	$94,273,372	$51,804,582
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$146,887,100	$124,731,100	$111,542,258	$92,632,694	$68,132,242	$37,481,671
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$15,105,718	$50,188,842	$55,909,563	$61,500,452	$67,650,572	$37,174,968
Unused Title XXI Funds Expiring (Allotment or Reallocated)	$44,050,282	$0	$0	$0	$0	$0
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$87,731,100	$74,542,259	$55,632,695	$31,132,242	$481,671	$306,703

Note: Federal Fiscal Year (FFY) 2001 is October 1, 2000 through September 30, 2001.

Attachment H — Additional Waivers or Expenditure Authority

In addition to the waivers specified in the body of the application, the State of Oregon requests two additional waivers.

1. Eligibility Screening

Oregon requests a waiver of the requirement to screen and enroll SCHIP children in Medicaid in the instance that families that are eligible for OHP Plus choose FHIAP. Section 2102(b)(3)(B) and 42 CFR 457.350(a) through (f) & 457.353 require that the State screen each application for SCHIP coverage to determine if applicant children might be eligible for Medicaid. Children who are found to be eligible for Medicaid must be enrolled in Medicaid. As described elsewhere in this application, Oregon intends to give families a choice. When a family applies for FHIAP, and it appears that some family members might also be eligible for OHP Plus (which will include Medicaid-enrolled children), families will be allowed to choose whether they wish to apply and enroll potentially eligible family members in OHP Plus or enroll the entire family in FHIAP. The State will comply with 42†CFR 457.350(g) and (h), which require the provision of information to families about potential Medicaid eligibility in order to allow families to make informed decisions. But Oregon believes that it is important to allow families to make these choices for themselves. Further, the State believes that families are fully capable of making appropriate choices about their children's health insurance coverage, if given the opportunity and the information needed to do so. Oregon therefore requests a waiver of the requirement that children applying for FHIAP must apply for and be enrolled in Medicaid, rather than FHIAP/SCHIP, if they appear to be eligible for Medicaid.

2. Annual Reporting Requirements

Oregon requests that the annual reporting requirements in Section 2108 not apply to the demonstration population.