

**STATE PLAN UNDER TITLE XIX
OF THE
SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM**

**Oregon Health Authority
State of Oregon**

**HCFA-AT-80-38 (BPP)
November 22, 2023**

The affordable Care Act of 2010 set forth a series of changes for Medicaid and CHIP eligibility. These SPA pages are shown below and the SPA templates are included in Section 8 of this State Plan.

SUPERSEDING PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: 13-0012MM		STATE: Oregon
Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S57, and S14 and related pages or sections of pages being deleted as obsolete. Refer to Section 8.		
State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 21 Page 23 Page 23c Page 23e	Page 2, A.2.b Page 2, A.2.c Page 2a, A.3 Page 5, A.10 Page 9c, B.1 remove “Caretaker relatives” and “Pregnant women” Page 20, B.14
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) and (2) Page 12, C.1.e(2) Page 18, C.5.e Page 25, 11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1-4	
Supplement 2 to Attachment 2.6-A	Pages 1-5a	

TN No. 13-0012-MM

Approval Date 12/10/13

Effective date 1/1/14

SUPERSEDING PAGES OF STATE PLAN MATERIAL

TRANSMITTAL NUMBER: 13-0012MM		STATE: Oregon
Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S57, and S14 and related pages or sections of pages being deleted as obsolete. Refer to section 8.		
State Plan Section	Complete Pages Removed	Partial Pages Removed
Supplement 8a to Attachment 2.6-A		Page 1-a, #2
Supplement 12 to Attachment 2.6-A	Page 2 Page 3	
Supplement 14 to Attachment 2.6-A	Page 1	

TN No. 13-0012-MM
Supersede TN No.

Approval Date 12/10/13

Effective date 1/1/14

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: OR-13-0013-MM2	STATE: Oregon
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>):

S94 – Eligibility Process	Section 2, Page 10, section 2.1(a), TN 91-25 Effective date: 1/1/91, approved: 1/23/92 Section 2, Page 11a, section 2.1(d), TN 91-24 Effective date: 7/1/91 , approved: 11/1/91
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TN No. 13-0013-MM2
Supersedes TN No.

Approval Date:3/21/14

Effective Date: 10/1/13

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
<input checked="" type="checkbox"/> Paper Application <input type="checkbox"/> Online Application	
TRANSMITTAL NUMBER: OR-13-0013-MM2	STATE: Oregon
Through November 30, 2014, the state is using an interim alternative single streamlined application. After November 30, 2014, the state will use a revised alternative single	

streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

TN No. 13-0013-MM2
Supersedes TN No.

Approval Date:3/21/14

Effective Date: 10/1/13

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application Online Application

TRANSMITTAL NUMBER:

OR-13-0013-MM2

STATE:

Oregon

Through November 30, 2014, the state is using an interim alternative single streamlined application. After November 30, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS

letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

TN No. 13-0013-MM2
Supersedes TN No.

Approval Date: 3/21/14

Effective Date: 10/1/13

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: OR-13-0014-MM3	STATE: Oregon
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S10 - MAGI Income Methodology	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Notwithstanding any other provisions of the Oregon Medicaid State Plan, the financial eligibility methodologies described in State

	<p>Plan Amendment OR-13-0014-MM3 will apply to all MAGI-based eligibility groups covered under Oregon's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone except those individuals described at 42 CFR § 435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.</p>
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TN No. 13-0014-MM3
Superseded TN No.

Approval Date: 1/10/14

Effective Date: 1/1/14

<p align="center">SUPERSEDING PAGES OF STATE PLAN MATERIAL</p>		
<p>TRANSMITTAL NUMBER: OR-13-0015-MM</p>	<p>STATE: Oregon</p>	
<p>PAGE NUMBER OG THE PLAN SECTION OR ATTACHMENT: A1-A3</p>	<p>COMPLETE PAGES SUPERSEDED: Page 1 Section 1.1 (pages 2-6) Section 1.2 (pages 7) Section 1.3(page) Attahment 1.1-A (Attorney</p>	<p>PARTIAL PAGES SUPERSEDED: Section 1.4 (page 9)(State Medical Care Advisory Committee only. Tribal consultation will remain in the state plan.)</p>

	<p>General certification)</p> <p>Attachment 1.2-A (Organizational chart)</p> <p>Attachment 1.2-B (Description of the functions of the single state agency)</p> <p>Attachment 1.2-C (Description of professional medical and supporting staff)</p> <p>Attachment 1.2-D</p>	
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TN No. 13-0015-MM
Superseded TN No.

Approval Date: 4/8/15

Effective Date: 1/1/14

<p align="center">SUPERSEDING PAGES OF STATE PLAN MATERIAL</p>	
<p>TRANSMITTAL NUMBER:</p> <p>OR-13-0016-MM5</p>	<p>STATE:</p> <p>Oregon</p>
<p>PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:</p> <p>S88 – Non-Financial Eligibility- State Residency</p>	<p>PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i>:</p> <p>Section 2, page 13, item 2.3, TN 87-12</p> <p>Attachment 2.6-A: Page 3, Item 4, TN 02-08</p>

**SUPERSEDING PAGES OF
STATE PLAN MATERIAL**

TN No. 13-0016-MM5
Supersedes TN No.

Approval Date: 3/21/14

Effective Date: 1/1/14

TRANSMITTAL NUMBER: OR-13-0017	STATE: Oregon
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S89 Non-Financial Eligibility- Citizenship and Non-citizen Eligibility	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.6-A: Page 2, Item 3, subparagraphs (a), (b) and (c), TN 09-10 Page 2a - Entire page, TN 09-10 Page 2b - Entire page, TN 09-10 Page 2c - Entire page, TN 09-10

TN No. 13-0017-MM6
Supersede TN No.

Approval Date: 3/24/14

Effective date 1/1/14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

Citation(s)

Replaced by ACA TN No. 13-0015-Section 8

1.4 ~~State Medical Care Advisory Committee~~

~~42 CFR~~

~~431.12(b)~~

~~AT 78-90~~

~~There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.~~

42 CFR

438.104



The State enrolls recipients in MCO, PIHP, PAHP and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

1902(a)(73)

Tribal Consultation Requirements

The Oregon Health Authority (OHA) has regular quarterly meetings with the nine federally recognized Tribes, Urban Indian Programs and Indian Health Service (IHS) representatives. The agenda's are mainly driven by the Indian communities of Oregon, Urban Indian Programs and Indian Health Service (IHS) representatives and are constructed by requesting topic's to be discussed at the meeting. These meetings are referred to in Oregon as Senate Bill 770 in reference to the legislation authoring the meeting. The OHA may engage the tribal and urban program representatives outside of the meeting setting through correspondence in the event a policy change is needed more quickly than the next 770 meeting will support. Each Tribe and Indian Organization selects its representative to the meetings based on whom the Tribe or Indian Organization feels is best to represent their needs.

The Division discusses proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have a direct impact on American Indians, Tribal entities and urban Indian programs or IHS in the SB 770 quarterly meetings.

TN No. 10-21

Approval Date: 3/21/11

Effective Date: 10/1/10

Supersedes TN No.03-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program**State/Territory:** OREGON

Citation(s)

1902(a)(73)

Tribal Consultation Requirements (continued)

Impacts that are considered to have direct affects on Native Americans, Urban Indian programs or IHS are changes that would impact eligibility determinations, changes that reduce payment rates or changes in payment methodologies, reductions in covered services, changes in provider qualifications/requirements, and proposals for demonstrations or waivers.

Process:

Thirty (30) days prior to a State Plan submission to the Centers for Medicare and Medicaid Services (CMS), the Division distributes documents describing a proposed State Medicaid Plan Amendments (SPA). This is normally discussed in a scheduled quarterly SB 770 meeting. Approximately ten (10) days prior to the quarterly 770 meeting the Division distributes the agenda and documents describing a proposed SPA. This is distributed through the Tribal Liaison to the nine federally recognized Tribes, Tribal Urban Indian programs and Indian Health Service (IHS) representatives. The types of entities on the distribution list includes, but is not limited to:

- a. Oregon Tribal Governments (i.e. Tribal Executive Council, Tribal Business Council, etc.)
- b. Tribal Chairman or Chief or their designated representative(s)
- c. Tribal Health Clinic Executive Directors of Oregon's 638/FQHC providers
- d. IHS representatives
- e. Tribal Organizations established to represent IHS and Tribal health programs and such as the Northwest Portland Indian Health Board
- f. Urban Indian program(s) Executive Director(s) or designee(s)

In instances where a SPA would need to be submitted prior to a regularly scheduled '770' meeting the Division would utilize electronic mail or schedule conference calls.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994

Transmittal # 10-21
OMB No. 0938-1098

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

Citation(s)

1902(a)(73)

Tribal Consultation Requirements (continued)

The Division may also utilize an expedited process in the event a deadline is outside the control of the Division, or in severely time limited situations. The expedited process includes at a minimum, 10 days in advance of the change the Division provides written notification with the proposed change; anticipated impact; method for providing comments/questions; timeframe for feedback; and an opportunity for a face-to-face meeting or conference call if requested.

Tribal, Urban Indian program and IHS designees are invited to attend all Divisions' Rule Advisory Committee meetings to provide additional input on rule concepts and language.

1.5

Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.
 - a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.
 - b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance ProgramState/Territory: OREGON

Citation(s)

1928 1.5
of the ActPediatric Immunization Program

- c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.
 - d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.
 - e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.
 - f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.
 - g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.
2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994

Transmittal # 10-21
OMB No. 0938-1098

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

Citation(s)

1928 1.5 Pediatric Immunization Program
of the Act

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

State Medicaid Agency

State Public Health Agency (Both agencies are under the single state agency authority)

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation(s)

Page removed by 13-0013, Form S94

- 42 CFR
435.10 and
Part
Subpart J
- 2.1 Application, Determination of Eligibility and Furnishing Medicaid
- (a) The Medicaid agency meets all requirements of 42 CFR
435, Subpart J for processing applications, determining
eligibility, and furnishing Medicaid.

TN No. 91-25
Supersedes TN No. 75-12

Approval Date 1/23/92

Effective Date 11/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation(s)

42 CFR 2.1(b) (1) Except as provided in items 2.1(b)(2) and (3) below,
435.915 individuals are entitled to Medicaid services under the
Plan 1902(a)(34) during the three months preceding the
month of application, if they were, or on
application would have been, eligible. The effective date
of prospective and retroactive eligibility is specified in
ATTACHMENT 2.6-A.

1902(e)(8) and ___ (2) For individuals who are eligible for Medicare cost-sharing
1905(a) of the expenses as qualified Medicare beneficiaries under section
Act 1902(a)(10)(E)(i) of the Act, coverage is available for
services furnished after the end of the month in which the
individual is first determined to be a qualified Medicare
beneficiary. ATTACHMENT 2.6-A specifies the
requirements for determination of eligibility for this group.

1902(a)(47) and ___ (3) Pregnant women are entitled to ambulatory prenatal care
1920 of the Act under the plan during a presumptive eligibility period in
accordance with section 1920 of the Act. ATTACHMENT
2.6-A specifies the requirements for determination of
eligibility for this group.

42 CFR 438.6 (c) The Medicaid agency elects to enter into a risk contract that
complies with 42 CFR 438.6 and is procured through an open,
competitive procurement process that is consistent with 45 CFR
Part 74. The risk contract is with (check all that apply):
___ Qualified under title XIII of the Public Health Service Act .
X A MCO that meets the definition of 1903(m) of the Act and
42 CFR 438.2.
___ A PIHP that meets the definition of 1903(m) of the Act and
42 CFR 438.2.
___ A PAHP that meets the definition of 1903(m) of the Act
and 42 CFR 438.2.
___ Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation(s)

Page removed by 13-0013, form S94

1902(a)(55)
of the Act

2.1(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.

TN No. 91-24

Supersedes

Approval Date 11/1/91

Effective Date 7/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid

1902(e)(13) of
the Act

(e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option.

(1) The Express Lane option is applied to:

- Initial determinations Redeterminations
- Both

(2) A child is defined as younger than age:

- 19 20 21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Medical Assistance Program

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Cont)

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

(a) Screening threshold established by the Medicaid agency as:

(i) ___ percentage of the Federal poverty level which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: specify FPL; or

(ii) ___ percentage of the Federal poverty level (that reflects the value of any differences between income methodologies of Medicaid and the Express Lane); or

(b) Temporary enrollment pending screen and enroll.

(c) State's regular screen and enroll process for CHIP.

(6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

(7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

Transmittal #03-04
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

Mandatory categorically needy and other required special groups only.

Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

Mandatory categorically needy, other required special groups, and specified optional groups.

Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(1) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

TN No. 03-04

Supersedes TN No. 02-14

Approval Date 03/11/03

HCFA ID: 7982E

Effective Date 02/01/03

Revision: HCFA-PH-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

Page removed by 13-0016, form S88

2.3 Residence

435.10 and
435.403, and
the
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

Medicaid is furnished to eligible individuals who are residents of

State under 42 CFR 435.403, regardless of whether or not the
individuals maintain the residence permanently or maintain it at a
fixed address.

TN No. 87-12
Supersedes TN No. _____

Approval Date 10/9/87

Effective Date 4/1/87

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

Transmittal #87-12
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.4 Blindness

42 CFR 435.530(b)
42 CFR 435.531
AT-78-90
AT-79-29

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met.
The more restrictive definition of blindness in terms of ophthalmic
measurement used in this plan is specified in ATTACHMENT 2.2-A.

TN No. 87-12
Supersedes TN No. _____

Approval Date 10/9/87

Effective Date 4/1/87

Revision: HCFA-PM-91-4(BPD)
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.5 Disability

42 CFR
435.121,
435.540(b)
435.541

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1(MB)
FEBRUARY 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.6 Financial Eligibility

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI) and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

- (a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

TN No. 92-5

Approval Date 5-14-92

Effective Date 1-1-92

Supersedes TN No. 91-25 & 91-4

Revision: HCFA-PM-86-20(BERC)
SEPTEMBER 1986

Transmittal #86-33
OMB-No. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.7 Medicaid Furnished Out of State

431.52 and
431.52
1902(b) of the
Act, P.L. 99-272
(Section 9529)

Medicaid is furnished under the conditions specified in 42 CFR
to an eligible individual who is a resident of the State while the
individual is in another State, to the same extent that Medicaid is
furnished to residents in the State.

TN No. 86-33
Supersedes TN No. 82-27

Approval Date 1/23/87

Effective Date OCT 1 1986

HCFA ID: 0053C/0062E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1 Amount, Duration, and Scope of Services

42 CFR (a)
Part 440,
Subpart B
1902(a), 1902(e),
1905(a), 1905(p),
1915, 1920, and
1925 of the Act

Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and
1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

— Not applicable. Nurse-midwives are not authorized to practice in this State.

TN No. 94-11
4/1/94

Approval Date 6/9/94

Effective Date

Supersedes TN No. 91-25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy
(Continued)

1902(e)(5) of day the Act	(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
1902(a)(10) (F) (VII) of the matter following (E) of the Act	<u>X</u> (iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
	(v)	Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

TN No. 91-25Approval Date 1/23/92Effective Date 11/1/91Supersedes TN No. 90-10

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD) Transmittal #03-11
 August 1991 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)		
<u>Needy</u>	3.1(a)(1)	<u>Amount, Duration, and Scope of Services: Categorically (Continued)</u>
		(vi) Home health service are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or Section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	—	(viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) section and 1925 of the Act		(ix) Services are provided to families eligible under 1925 of the Act as indicated in item 3.5 of this plan.

Revision: HCFA-PM-91-4 (BPD)
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

Citation(s)		<u>Amount, Duration, and Scope of Services: Categorically</u> (Continued)
<u>Needy</u>	3.1(a)(1)	
1905(a)(26) and 1934	<u>X</u>	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial service provided to the categorically needy. (NOTE: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits - for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN No. 03-11 Approval Date 9/26/03
Supersedes TN No. _____

Effective Date 10/1/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy
(Continued)1915(j) X Self-Directed Personal Assistance Services, as described
and limited in Supplement 3 to Attachment 3.1-A.ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically
needy.TN No. 13-09
Supersedes TN No.

Approval Date

Effective Date 7/1/13
HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1 Amount, Duration, and Scope of Services (continued)42 CFR Part 440,
Subpart B(a)(2) Medically needy.

_____ This State plan covers the medically needy.
The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv)
of the Act
care
42 CFR 440.220

- (i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

_____ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of
women.
the Act

- (ii) Prenatal care and delivery services for pregnant

TN No. 03-04

Approval Date 03/11/03

Effective Date 02/1/03

Supersedes TN No. 02-14

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)		
	3.1(a)(2)	<u>Amount, Duration, and Scope of Services: Medically Needy (Continued)</u>
	(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
_____	(iv)	Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.
	(v)	Ambulatory services, as defined in <u>ATTACHMENT 3.1-B</u> , for recipients under age 18 and recipients entitled to institutional services.
	<u>XX</u>	Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.
	(vi)	Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.
42 CFR 440.140, 440.150, Subpart B, 442.441, retarded. Subpart C 1902(a)(20) and (21) of the Act 1902(a)(10)(C)	_____	(vii) Services in an institution for mental diseases for individuals over age 65.
	_____	(viii) Services in an intermediate care facility for the mentally
	_____	(ix) Inpatient psychiatric services for individuals under age 21.

TN No. 03-04

Approval Date 03/11/03

Effective Date 02/01/03

Supersedes TN No. 02-14

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #03-11
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

Citation(s)	3.1(a)(2)	<u>Amount, Duration, and Scope of Services: Medically Needy</u> (Continued)
1902(e)(9) of Act	_____	(ix) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1905(a)(26) and 1934	_____	Program of all-inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (NOTE: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits - for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN No. 03-11 Approval Date 9/26/03
Supersedes TN No. 91-25

Effective Date 10/1/03

HCFA ID: 7982E

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

Transmittal No. 98-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)		
	3.1	<u>Amount, Duration, and Scope of Services</u> (continued)
	(a)(3)	<u>Other Required Special Groups: Qualified Medicare Beneficiaries</u>
1902(a)(10)(E)(i) and clause (VIII) following (F), of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is of the matter provided only as indicated in tem 3.2 of this plan. and 1905(p)(3)
1902(a)(10) and (E)(ii) and 1905(s) of the Act	(a)(4)(i)	<u>Other Required Special Groups: Qualified Disabled Working Individuals</u>
		Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a) (10) (E) (ii)of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10) (E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	<u>Other Required Special Groups: Specified Low-Income Medicare Beneficiaries</u>
		Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902 (a) (10) (E) (iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10) (E)(iv)(I)1905(p)(3) (A)(ii) and 1933 of the Act	(iii)	<u>Other Required Special Groups Qualifying Individuals - 1</u>
		Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

TN No. 98-10 Approval Date 9/23/98
Supersedes TN No. 98-02

Effective Date 4/1/98

Revision: HCFA-PM-98-1
April 1998

(CMSO)

Transmittal NO.. 98-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

1902(a)(10)
(E)(iv)(II), 1905(p)(3)
(A)(iv)(II), 1905(p)(3)
the Act

(iv) Other Required Special Groups: Qualifying
Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the
Act

(a)(5)

Other Required Special Groups: Families
Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

	3.1	<u>Amount, Duration and Scope of Services:</u> (Continued)
1902(a) and 1903(v) of the Act, Sec. 401(b)(1)(A) of P.L.	(a)(6)	<p>Limited Services for Certain Aliens:</p> <p>An otherwise eligible non-qualified alien or, qualified alien 104-193 subject to the 5-year bar, is eligible only for care and services necessary to treat an emergency medical condition of the alien, as defined in section 1903(v) of the Act. The State applies the plain language of section 1903(v) to determine payment for such services.</p>
1905(a)(9) of the Act	(a)(7)	<p><u>Homeless Individuals.</u></p> <p>Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.</p> <p><u>Presumably Eligible Pregnant Women</u></p>
1902(a)(47) and 1920 of the Act	(a)(8)	<p>Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.</p>
42 CFR 441.55 (a)(9) 50 F.R. 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act		<p><u>EPSDT Services.</u></p> <p>The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.</p>

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

- 3.1 (a)(6) Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
- 1902(a) and 1903(v) residence of the Act (iii) Aliens who are not lawfully admitted for permanent or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
- 1905(a)(9) of the Act (a)(7) Homeless Individuals.
Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
- 1902(a)(47) and 1920 of that the Act (a)(8) Presumably Eligible Pregnant Women
Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider is eligible for payment under the State plan.
- 42 CFR 441.55 (a)(9) EPSDT Services.
50 F.R. 43654
1902(a)(43),
1902(a)(43),
1905(a)(4)(B),
periodic
and 1905(r) of the Act
The Medicaid agency meets the requirements of sections 1905(a)(4)(B), and 1905(r) of the Act with respect to early and screening, diagnostic, and treatment (EPSDT) services.

TN No. 91-25
Supersedes TN No. _____

Approval Date 1/23/92

Effective Date 11/1/91

HCFA ID: 7982E

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

Transmittal #03-13
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

	3.1	(a)(9)	<u>Amount, Duration, and Scope of services: EPSDT Services (continued)</u>
42 CFR 441.60	<u>X</u>		The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.
42 CFR 440.240 and 440.250		(a)(10)	<u>Comparability of Services</u>
1902(a) and 1902 (a)(10), 1902(a)(52) 1903(v), 1915(g), and 1925(b)(4) and 1932 the Act			<p style="text-align: right;">P&I</p> <p>Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:</p> <p>(i) Services made available to the categorically needy of are equal in amount, duration, and scope for each categorically needy person.</p> <p>(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.</p> <p>(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.</p>
	<u>X</u>	(iv)	Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

TN No. 03-13 Approval Date 11/6/03
Supersedes TN No. 91-25

Effective Date: 8/13/03

CFA ID: 7982E

The Agency conducts a yearly medical audit of each contractor. One of the elements of the audit is review of medical records specifically related to EPSDT services.

Revision: HCFA-AT-80-38 (BPP)
 May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

- | | |
|--|---|
| 42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34 | 3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

<input checked="" type="checkbox"/> Yes

___ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

___ Yes, to all

___ Yes, to individuals age 21 or over; SNF services are provided

___ Yes, to individuals under age 18; SNF services are provided

___ No; SNF services are not provided

<input checked="" type="checkbox"/> Not applicable; the medically needy are not included under this plan |
|--|---|

TN No. 03-04

Approval Date 03/11/03

Effective Date 02/01/03

Supersedes TN No. 02-14

HCFA ID: 7982E

Revision: HCFA-PM-93-8 (BPD)
December 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10(c)(8)(i).

TN No. 94-02

Approval Date 2/23/94

Effective Date 10/1/93

Supersedes TN No. 91-25

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure
Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

TN No. 759-1

Approval Date 4/9/74

Effective Date 1/1/74

Supersedes TN No. 759

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1(e)

Family Planning Services

42 CFR 441.20
AT-78-90

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN No. 759-1

Supersedes

Approval Date 4/9/74

Effective Date 1/1/74

TN No. 759

Revision: HCFA-PM-87-5
APRIL 1987

(BERC)

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

42 CFR 441.30 AT-78-90	3.1 (f) (1)	<u>Optometric Services</u>	Optometric services (other than those provided under §435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.
		<input checked="" type="checkbox"/>	Yes.
		<input type="checkbox"/>	No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.
		<input type="checkbox"/>	Not applicable. The conditions in the first sentence do not apply.
1903(i)(1) of the Act, P.L. 99-272 (Section 9507)	(2)	<u>Organ Transplant Procedures</u>	Organ transplant procedures are provided.
		<input type="checkbox"/>	No.
		<input checked="" type="checkbox"/>	Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at <u>ATTACHMENT 3.1-E</u> .

TN No. 16-0009Approval Date: 12/19/16Effective Date 7/1/16Supersedes TN No. 87-10

HCFA ID: 1008P/0011P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for at least 30 consecutive days.
- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) Wish to be cared for at home.

Yes. The requirements of section 1902(e)(9) of the Act are met.

Not applicable. These services are not included in the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy
(Continued)

3.1 (i) **Medication-Assisted Treatment (MAT)**

1905(a)(29) X MAT as described and limited in Supplement 5 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and
1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Group premium payment
Arrangement for Part A

Buy-In agreement for:

Part A Part B

The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
DECEMBER 1997

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

- | | | |
|--|-------|---|
| 1902(a)(10)(E)(ii)
and 1905(s) of the Act | (ii) | <p><u>Qualified Disabled and Working Individual (QDWI)</u></p> <p>The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in <u>ATTACHMENT 4.18-E</u>, for individuals in the QDWI group defined in item A.26 of <u>ATTACHMENT 2.2-A</u> of this plan.</p> |
| 1902(a)(10)(E)(iii)
and 1905(p)(3)(A)(ii)
of the Act | (iii) | <p><u>Specified Low-Income-Medicare Beneficiary (SLMB)</u></p> <p>The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of <u>ATTACHMENT 2.2-A</u> of this plan.</p> |
| 1902(a)(10)(E)(iv)(I)
1905(p)(3)(A)(ii), and
1933 of the Act | (iv) | <p><u>Qualifying Individual-1 (QI-1)</u></p> <p>The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.</p> |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

1843(b) and 1905(a)
of the Act and
42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

X All individuals in Group 2 per 42 CFR 407.42(b).

— Individuals receiving title II or Railroad Retirement benefits.

— Medically needy individuals (FFP is not available for this group).

1902(a)(30) and
1905(a) of the Act

(2) Other Health Insurance

— The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

TN No. 8-03Approval Date 5/23/08Effective Date 4/1/08Supersedes TN No. 98-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

	(b) <u>Deductible/Coinsurance</u>	
	(1) Medicare Part A and B	
1902(a)(30), 1902(n), 1905(a), and 1916 of the Act		<u>Supplement 1 to ATTACHMENT 4.19-B</u> describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.
Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act	(i) <u>Qualified Medicare Beneficiaries (QMBs)</u>	The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.
1902(a)(10), 1902(a)(30), and 1905(a) of the Act	(ii) <u>Other Medicaid Recipients</u>	The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:
42 CFR 431.625	-	For the entire range of services available under Medicare Part B.
	X	Only for the amount, duration, and scope of services otherwise available under this plan.
1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act	(iii) <u>Dual Eligible--QMB plus</u>	The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

TN No. 93-5 Approval Date 7/2/93
Supersedes TN No. 91-25

Effective Date 4/1/93

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

Condition or Requirement

1906 of the
Act

(c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).

1902(a)(10)(F)
of the Act

(d) _____ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

TN No. 92-3

Approval Date 4/8/92

Effective Date 1/1/92

Supersedes TN No. _____

HCFA ID: 7983E

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in
Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who
are patients in institutions for mental diseases.

X Yes. The requirements of 42 CFR Part 441, Subpart C, and
42 CFR 431.620(c) and (d) are met.

 Not applicable. Medicaid is not provided to aged individuals,
in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

42 CFR 441.252 AT-78-99	3.4	<u>Special Requirements Applicable to Sterilization Procedures</u> All requirements of 42 CFR Part 441, Subpart F are met.
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TN No. 79-1
Supersedes
TN No. 74-7

Approval Date 4/10/79

Effective Date 3/12/79

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

1902(a)(52) and 1925 of the Act	3.5 (a)	<p style="text-align: center;"><u>Families Receiving Extended Medicaid Benefits</u></p> <p>Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in <u>ATTACHMENT 3.1-A</u> (or may be greater if provided through a caretaker relative employer's health insurance plan).</p> <p>(b) Services provided to families during the second-month period of 6-month extended Medicaid benefits under section 1925 of the Act are--</p> <p><u>X</u> Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in <u>ATTACHMENT 3.1-A</u> (or may be greater if provided through a caretaker relative employer's health insurance plan).</p> <p>— Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:</p> <p>— Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.</p> <p>— Medical or remedial care provided by licensed practitioners.</p> <p>— Home health services.</p>
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TN No. 91-25
Supersedes TN No. 89-3

Approval Date 1/23/92

Effective Date 11/1/91
HCFA ID: 7982E

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.5 Families Receiving Extended Medicaid Benefits (Continued)

- Private duty nursing services.
- Physical therapy and related services.
- Other diagnostic, screening, preventive, and rehabilitation services.
- Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- Intermediate care facility services for the mentally retarded.
- Inpatient psychiatric services for individuals under age 21.
- Hospice services.
- Respiratory care services.
- Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

TN No. 91-25

Supersedes Approval Date 1/23/92

Effective Date 11/1/91

TN No. 87-18HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

1st 6 months 2nd 6 months

The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

1st 6 months 2nd 6 months

(d) (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

Enrollment in the family option of an employer's health plan.

Enrollment in the family option of a State employee health plan.

Enrollment in the State health plan for the uninsured.

Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

TN No. 91-25
Supersedes
TN No. 90-10

Approval Date 1/23/92Effective Date 11/1/91

HCFA ID: 7982E

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

Transmittal #91-25
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2)The agency--

- (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).
- (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

TN No. 91-25

Supersedes Approval Date 1/23/92

Effective Date 11/1/91

TN No. 90-10HCFA ID: 7982E

Revision: HCFA-PM-87- 4 (BERC)
MARCH 1987

Transmittal #87-19
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

TN No. 87-19
Supersedes
TN No. 759-1

Approval Date 9/24/87

Effective Date 4/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-ROX-1 (BPP)
November 1990

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.2 Hearings for Applicants and Recipients

42 CFR 431.202

AT-79-29

AT-80-34

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part431, Subpart E.

1919(e)(3)

With respect to transfers and discharges from nursing facilities, the requirements of 1919(e)(3) are met.

TN No. 90-31

Supersedes

TN No. 74-5

Approval Date 1/29/91

Effective Date 10/1/90

Revision: HCFA--AT-87-9 (BERC)
AUGUST 1987

Transmittal #87-40
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.3 Safeguarding Information on Applicants and Recipients

42 CFR 431.301
AT-79-29

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

TN No. 87-40
Supersedes
TN No. 759-1

Approval Date 1/25/88

Effective Date 10/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.4 Medicaid Quality Control

42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of
the Act,
P.L. 99-509
(Section 9407)

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

Yes.

Not applicable. The State has an approved Medicaid Management Information System (MMIS).

TN No. 87-19
Supersedes
TN No. 85-18

Approval Date 9/24/87

Effective Date 4/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

Transmittal #88-26
MB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.5 Medicaid Agency Fraud Detection and Investigation Program

42 CFR 455.12
AT-78-90
criteria
48 FR 3742,
52 FR 48817

The Medicaid agency has established and will maintain methods, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TN No. 88-26
Supersedes
TN No. 83-15

Approval Date 1/24/89

Effective Date 10/1/88

HCFA ID: 1010P/0012P

36a

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

Section 1902(a)(64) of
the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation
Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN# 99-13

Supersedes

TN# ---

Approval Date 12/17/99

Effective Date 10/1/99

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Medical Assistance Program

State/Territory: OREGON

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.5b Medicaid Recovery Audit Contractor program

Section 1902(a)(42) (b)(i) of the Act The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

The State is seeking an exception to establishing such program for the following reasons:

Section 1902(a)(42) (B)(ii)(I) of the Act The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

The State is requesting an exception to 42 CFR § 455.508(f) so that the Medicaid RAC will be allowed to review claims that are up to seven years old, with the start date being the date the claim was submitted to the State or one of its agents. This exception is required for the following reasons:

- Claim specific detail may be present documenting an overpayment exists for periods beyond the three years specified in Section 42 CFR 455.508(f);
- A look back period longer than three years is more consistent with OHA Medicaid provider record retention requirements.

There is no time limits on the look back period when fraud is involved.

Place a check mark to provide assurances of the following:

- The State will make payments to the RAC(s) only from amounts recovered.
- The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902(a)(42) (B)(ii)(II)(aa) of the Act The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

TN No. 17-0008Approval Date: 10/2/17Effective Date: 10/1/17Supersedes TN No. 11-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.5b Medicaid Recovery Audit Contractor program (Cont)

- The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount.
 - The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
 - The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
- Section 1902(a)(42)(B)(ii)(II)(bb) Of the Act
- Section 1902(a)(42)(B)(ii)(III) of the Act
- Section 1902(a)(42)(B)(ii)(IV)(aa) of The Act
- Section 1902(a)(42)(B)(ii)(IV)(bb) of The Act
- Section 1902(a)(42)(B)(ii)(IV)(cc) of The Act

TN No. 17-0008

Approval Date: 10/2/17

Effective Date: 10/1/17

Supersedes TN No. 11-02

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.6 Reports

42 CFR 431.16
AT-79-29

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

TN No. 759-1

Supersedes

Approval Date 4/9/74

Effective Date 1/1/74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

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Citation(s)

42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN No. 759-1
Supersedes
TN No. 759

Approval Date 4/9/74

Effective Date 1/1/74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 431.18(b) AT-79-29	<p>4.8 <u>Availability of Agency Program Manuals</u></p> <p>Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.</p>
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TN No. 759-1

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TN No. 759

Approval Date 4/9/74

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.9 Reporting Provider Payments to Internal Revenue Service

42 CFR 433.37
AT-78-90
433.37

There are procedures implemented in accordance with 42 CFR for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for service under the Plan.

TN No. 759-1
Supersedes
TN No. 759

Approval Date 4/9/74

Effective Date 1/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)

	4. 10	<u>Free Choice of Providers</u>
42 CFR 431.51 AT-78-90 46 FR 48524 48 FR 23212 1902 (a) (23) of the Act P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)		<p>(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.</p> <p>(b) Paragraph (a) does not apply to services furnished to an individual--</p> <p>(1) Under an exception allowed under 42 CFR 431.54, Subject to the limitations in paragraph (c), or</p> <p>(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or</p> <p>(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, (P&I)</p> <p>(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services. <u>or</u></p> <p>(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).</p> <p>(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a),1915(b)(1), or 1932(a); managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services under section 1905(a)(4)(c).</p>
Section 1902(a)(23) of the Social Security Act P.L. 105-33		
Section 1932(a)(1) Section 1905(t)		

TN#03-13

Date Approved 11/6/03

Effective Date 8/13/03

Supersedes TN# 99-13

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- | | |
|---|--|
| <p>42 CFR 431.610
AT-78-90
AT-80-34</p> | <p>4.11 <u>Relations with Standard-Setting and Survey Agencies</u></p> <p>(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is <u>The Oregon Health Authority</u>.</p> <p>(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): <u>The Oregon Health Authority</u>.</p> <p>(c) <u>ATTACHMENT 4.11-A</u> describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Centers for Medicare and Medicaid Services on request.</p> |
|---|--|

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

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Citation(s)

4 CFR 431.610 AT-78-90 AT-89-34 The	4.11 (d) the	The <u>Department of Human Services</u> (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.
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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.12 Consultation to Medical Facilities

42 CFR 431.105(b)
AT-78-90

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to the type of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

Yes, as listed below:
ICF/Homes for the Aged

Not applicable. Similar services are not provided to other types of medical facilities.

TN No. 759-1

Supersedes

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TN No. 759

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AUGUST 1991

Transmittal #91-25
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- | | | |
|------------------------------------|-----|--|
| 42 CFR 431.107 | (a) | For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met. |
| 42 CFR Part 483
1919 of the Act | (b) | For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met. |
| 42 CFR Part 483,
Subpart D | (c) | For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met |
| 1920 of the Act | (d) | For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met. |

___ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

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October 1991

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)

1902(a)(58)

1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights
 - (b) under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (c) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (d) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

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Citation(s)

statutory or recognized by the courts) concerning advance directives; and (P&I)

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
 - (a) Hospitals at the time an individual is admitted as an inpatient.
 - (b) Nursing facilities when the individual is admitted as a resident.
 - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
 - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
 - (e) Managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (P&I) and health insuring organizations (as applicable) at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

___ Not applicable. No State law or court decision exist regarding advance directives.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.14 Utilization/Quality Control

42 CFR 431.60

42 CFR 456.2

50 FR 15312

1902(a)(30)(C) and

1902(d) of the
 Act, P.L. 99-509

(Section 9431)

- (a) A statewide program of surveillance and utilization control has been implemented safeguards against unnecessary or inappropriate use of Medicaid services available under use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

Directly

By undertaking medical and utilization review requirements through a contract with a utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

- (1) Meets the requirements of §434.6(a);
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the services and providers subject to PRO review;
- (4) Ensures that PRO. review activities are not inconsistent with the PRO review of Medicare services; and
- (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2) and
 1902(d) of the
 Act, P.L. 99-5509
 (Section 9431)

A Qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438, Subpart E, each managed care organization, prepaid inpatient health plan, and health insuring organization under contract, except where exempted by regulation.

TN No. 04-01

Approval Date 3/16/04

Effective Date 3/1/04

Supersedes TN No. 92-8

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

OMB No. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 456.2
50 F.R. 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

All hospitals (other than mental hospitals).

Those specified in the waiver.

No waivers have been granted.

TN No. 85-14

Supersedes

TN No. 75-11

Approval Date 9/19/85

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JULY 1985

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 456.2 50 FR 15312	4.14 (c)	<p>The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.</p> <p><input checked="" type="checkbox"/> Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.</p> <p><input type="checkbox"/> Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:</p> <p style="padding-left: 40px;"><input type="checkbox"/> All mental hospitals.</p> <p style="padding-left: 40px;"><input type="checkbox"/> Those specified in the waiver.</p> <p><input type="checkbox"/> No waivers have been granted.</p> <p><input type="checkbox"/> Not applicable. Inpatient services in mental hospitals are not provided under this plan</p>
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TN No. 85-19

Supersedes

TN No. 85-14

Approval Date 9/19/85

Effective Date 7/1/85

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

OMB NO. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 456.2
50 FR 15312 4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.

TN No. 85-14
Supersedes
TN No. 75-11

Approval Date 9/19/85

Effective Date 7/1/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

OMB NO. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 456.2
50 FR 15312
4.14 ___ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

___ Facility-based review.

___ Direct review by personnel of the medical assistance unit of the State agency.

___ Personnel under contract to the medical assistance unit of the State agency.

___ Utilization and Quality Control Peer Review Organizations.

___ Another method as described in ATTACHMENT 4.14-A.

X Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

___ Not applicable. Intermediate care facility services are not provided under this plan.

TN No. 85-14

Supersedes

Approval Date 9/19/85

Effective Date 7/1/85

TN No. 75-11

HCFA ID: 0048P/0002P

Revision: HCFA-PM- 91-10 (MB)
DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR Part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354 The State must ensure that an External Quality Review
42 CFR 438.356(b) and (d) Organization and its subcontractors performing the External Quality Review or External Quality review-related activities meets the competence and independence requirements.

___ Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part	<input checked="" type="checkbox"/>	The State has contracted with a Peer Review Organization (PRO)
456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	<input type="checkbox"/>	to perform inspection of care for: ICFs/MR;
	<input checked="" type="checkbox"/>	Inpatient psychiatric facilities for recipients under age 21; and
	<input checked="" type="checkbox"/>	Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30)	<input checked="" type="checkbox"/>	All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.
	<input type="checkbox"/>	Not applicable with respect to intermediate care facilities or for the mentally retarded services; such services are not provided under this plan.
	<input type="checkbox"/>	Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.
	<input type="checkbox"/>	Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN No. 92-14Approval Date 6/1/92Effective Date 4/1/92Supersedes TN No. 76-4

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

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TN No. 04-03

Approval Date 3/3/04

Effective Date 1/1/04

Supersedes TN No. 80-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries(a) Liens

— The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

— The State imposes liens on real property on account of benefits incorrectly paid.

— The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

— The State imposes liens on both real and personal property of an individual after the individual's death

TN No. 02-01

Approval Date 4/17/02

Effective Date 4/1/02

Supersedes TN No. 95-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

— Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2) — The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under '1917(a)(1)(B) (even if it does not impose those liens).

- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

During the time an individual was receiving nursing facility services or home and community-based services the State recovers all approved services, except for Medicare cost sharing identified at 4.17(b)(3)(i) & (ii).

TN No. 13-21Approval Date: 1/3/14Effective Date: 10/1/13Supersedes TN No. 10-23

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.17(b) Adjustments or Recoveries

(3) (Continued)

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

TN No.10-05
Supersedes TN No.

Approved: 5/18/10

Effective Date: 4/1/10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- (4) The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long-term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.
- The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long-term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long-term care insurance policy-based asset or resource disregard must select this entry. These five states may either check this entry or one of the following entries.)
- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.
- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long-term care services provided on behalf of the individual to the extent described below:
- 1917(b)(1)(C) If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

TN #07-07Approval Date 10/18/07Effective Date 1/1/08Supersedes TN #02-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

 (c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR '433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
 - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
 - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN No. 02-01

Approval Date 4/17/02

Effective Date 4/1/02

Supersedes

TN No. 95-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- (d) ATTACHMENT 4.17-A
- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
 - (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
 - (3) Defines the following terms:
 - o estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
 - o individual's home
 - o equity interest in the home
 - o residing in the home for at least 1 or 2 years,
 - o on a continuous basis,
 - o discharge from the medical institution and return home, and
 - o lawfully residing.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

TN No. 02-01

Approval Date 4/17/02

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Supersedes TN No. 95-10

Revision: HCFA-PM-91-4 (BPD)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

(Intentionally left blank)

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

(Intentionally left blank)

56

Revision: HCFA-PM-91- 4
AUGUST 1991

(BPD)

Transmittal #16-0010
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

(Intentionally left blank)

TN No. 16-0010

Approval Date:1/5/17

Effective Date 01/01/17

Supersedes TN No. 01-18

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
August 1991

Transmittal #01-18
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.18(b)(3) (Continued)

42 CFR 447.51
through 447.58

- (iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:
- (A) Service(s) for which a charge(s) is applied;
 - (B) Nature of the charge imposed on each service;
 - (C) Amount(s) of and basis for determining the charge(s);
 - (D) Method used to collect the charge(s);
 - (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
 - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
 - (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

 X Not applicable. There is no maximum.

TN No. 01-18

Approval Date 4/24/02

Effective Date 02/01/02

Supersedes TN No. 91-25

HCFA ID: 7962E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- 1916(c) of the Act 4.18(b)(4) ____ A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
- 1902(a)(52) and 1925(b) of the Act 4.18(b)(5) ____ For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
- 1916(d) of the Act 4.18(b)(6) ____ A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

TN No. 01-18
Supersedes TN No. 91-25

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HCFA ID: 7982E

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

Transmittal #03-04
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.18(c) Individuals are covered as medically needy under the plan.

42 CFR 447.51
through 447.58

(1) An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through
447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

 Age 19

 Age 20

 Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

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AUGUST 1991

Transmittal #01-18
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

	4.18	(c)(2) (Continued)
42 CFR 447.51 through 447.58	(ii)	Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.
	(iii)	All services furnished to pregnant women.
		<u> </u> Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
	(iv)	Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
	(v)	Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
	(vi)	Family planning services and supplies furnished to individuals of childbearing age.
1916 of the Act, P.L. 99-272 (Section 9505)	(vii)	Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.
447.51 through 447.58	(viii)	Services provided by a health maintenance organization (HMO) to enrolled individuals.
		<u> X </u> Not applicable. No such charges are imposed.

TN No. 01-18
Supersedes TN No. 91-25

Approval Date 4/24/02

Effective Date: 02/01/02

HCFA ID: 7982E

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AUGUST 1991

Transmittal #01-18
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.18 (c) (3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

18 or older

19 or older

20 or older

21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

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AUGUST 1991

Transmittal #01-18
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.18(c)(3) (Continued)

447.51 through
447.58

- (iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:
- (A) Service(s) for which charge(s) is applied;
 - (B) Nature of the charge imposed on each service;
 - (C) Amount(s) of and basis for determining the charge(s);
 - (D) Method used to collect the charge(s);
 - (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
 - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
 - (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

X Not applicable. There is no maximum.

TN No. 01-18

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AUGUST 1991

Transmittal #91-25
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
respect
and 1923 of
the Act

- (a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

___ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

*X Inappropriate level of care days are not covered.

*Under the state's DRG-based reimbursement system, hospitals are paid a prospectively determined rate, which is set in consideration of the costs incurred in appropriately treating patients in that DRG. If a hospital keeps a patient more days than are medically necessary, the hospital will not receive any additional reimbursement.

Inappropriate level of care days occurring in small rural hospitals in the state which are not paid under the DRG system, are identified by our post-payment utilization review program (contracted to the P.R.O.). Payments associated with such days are recovered by the Medicaid agency.

TN No. 91-25

Supersedes

Approval Date 1/23/92

Effective Date 11/01/91

TN No. 87-19

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August 1993

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

<p>42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act</p>	<p>4.19(b) In addition to the services specified in paragraphs 4.19(a),(d),(k),(1), and (m),the Medicaid agency meets the following requirements:</p> <p>(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally Qualified Health Centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC Services. <u>ATTACHMENT 4.19-B</u> describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).</p> <p>(2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.</p> <p><u>ATTACHMENT 4.19-B</u> describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.</p>
<p>1902(a)(10) and 1902(a)(30) of the Act</p>	<p><u>SUPPLEMENT 1</u> to <u>ATTACHMENT 4.19-B</u> describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.</p>

TN No. 93-17

Supersedes

TN No. 91-25

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Effective Date 10/1/93

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 447.40
AT-78-90 4.19(c) Payment is made to reserve a bed during a recipient's
temporary absence from an inpatient facility.

Yes. The State's policy is described in ATTACHMENT
4.19-C.

No.

TN No. 77-8

Supersedes

TN No. 76-15

Approval Date 1/19/78

Effective Date 10/1/77

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- 42 CFR 447.252
47 FR 47964
48 F. 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
- 4.19 (d)
- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.
- ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate Care facility services.
- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.
- At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.
- At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.
- Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.
- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.
- At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.
- At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.
- Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.
- (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

TN No. 88-16Supersedes TN No. 87-40Approval Date 9/30/88Effective Date 7/1/88

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 447.45(c)
AT-79-50

4.19(e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN No. 79-14

Supersedes

Approval Date 12/14/79

Effective Date 10/1/79

TN No.

Revision: HCFA-PM-87-4
MARCH 1987

(BERC)

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

<p>42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730</p>	<p>4.19(f)</p>	<p>The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.</p> <p>No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.</p>
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TN No. 87-19

Supersedes

TN No. 83-6

Approval Date 9/24/87

Effective Date 4/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.
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TN No. 77-1
Supersedes
TN No. 76-15

Approval Date 6/17/77

Effective Date 2/22/77

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 447.201	4.19 (h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.
42 CFR 447.20 AT-78-90		

TN No. 77-1
Supersedes
TN No. 76-15

Approval Date 6/17/77

Effective Date 2/22/77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 447.201	4.19 (i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available
42 CFR 447.204 AT-78-90		to recipients at least to the extent that those services are available to the general population.

TN No. 77-1
Supersedes
TN No. 76-15

Approval Date 6/17/77

Effective Date 2/22/77

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

Transmittal #91-25
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 4.19 (j) The Medicaid agency meets the requirements of 42 CFR 447.205
447.201 for public notice of any changes in Statewide method or standards
and 447.205 for setting payment rates.

1903(v) of (k) The Medicaid agency meets the requirements of section 1903(v) of
the Act the Act with respect to payment for medical assistance furnished to
an alien who is not lawfully admitted for permanent residence or
otherwise permanently residing in the United States under color of
law. Payment is made only for care and services that are necessary
for the treatment of an emergency medical condition, as defined in
section 1903(v) of the Act.

TN No. 91-25
Supersedes
TN No. 87-40

Approval Date 1/23/92

Effective Date 11/1/91

HCFA ID: 7982E

Revision: HCFA-PM-92-7 (MB)
October 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

1903(i)(14)
of the Act

4.19(1)

The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

TN No. 92-19

Supersedes

TN No. 81-28

Approval Date 1/12/93

Effective Date 1/1/93

Revision: HCFA-PM-94-8 (MB) Transmittal #94-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)
(C)(ii) of
the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

1926 of (iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

TN No. 94-17
Supersedes TN No.

Approval Date 3/13/95

Effective Date 10/1/94

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 447.25(b) AT-78-90	4.20	<p><u>Direct Payments to Certain Recipients for Physicians' or Dentists' Services</u></p> <p>Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.</p> <p><input type="checkbox"/> Yes, for <input type="checkbox"/> physicians' services <input type="checkbox"/> dentists' services</p> <p><u>ATTACHMENT 4.20-A</u> specifies the conditions under which such payments are made to recipients.</p> <p><input checked="" type="checkbox"/> Not applicable. No direct payments are made to recipients.</p>
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TN No. 74-8
Supersedes
TN No. 759-1

Approval Date 8/8/74

Effective Date 7/1/74

Revision: HCFA-AT-81-34 (BPP)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.21 Prohibition Against Reassignment of Provider Claims

42 CFR 447.10(c)
AT-78-90
46 FR 42699

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN No. 81-28

Supersedes

TN No. 78-10

Approval Date 12/11/81

Effective Date 10/01/81

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.22 Third Party Liability

- 42 CFR 433.137 (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
 - (2) 42 CFR 433.145 through 433.148.
 - (3) 42 CFR 433.151 through 433.154.
 - (4) Sections 1902(a)(25)(H) and (I) of the Act.
- 1902(a)(25)(H) and (I) of the Act
- 42 CFR 433.138(f) (b) ATTACHMENT 4.22-A --
- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
 - (2) Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
 - (3) Describes the methods the agency used for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138 (d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and
 - (4) Describes the methods the agency uses for following up paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.
- 42 CFR 433.138(g)(1)(ii) and (2)(ii)
- 42 CFR 433.138(g)(3)(i) and (iii)
- 42 CFR 433.138(g)(4)(i)

TN No. 96-08

Supersedes

TN No. 90-15Approval Date 7/19/96Effective Date 4/1/96

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 433.139 (b)(3)(i)	<u>X</u>	(c)	The State will make payment for pediatric preventive services, including early and periodic screening, diagnosis, and treatment services, without regard to third party liability and seek reimbursement from any liable third party to the extent of such legal liability, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.
42 CFR 433.139 (b)(3)(ii)(A)			Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	<u>ATTACHMENT 4.22-B</u> specifies the following:
42 CFR 433.139(b)(3)(ii)(C)		(1)	The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20	(e)		The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.22 (continued)

- 42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)
- State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.
- Other appropriate State agency(s)--
- Other appropriate agency(s) of another State--
- Courts and law enforcement officials.
- 1902(a)(60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.
- 1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.
- The Secretary's method as provided in the State Medicaid Manual, Section 3910.
- The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

TN No. 96-08
 Supersedes
 TN No. 90-15

Approval Date 7/19/96Effective Date 4/1/96

Revision: HCFA-AT-84-2 (BERC)
01-84

OMB No. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.23 Use of Contracts

42 CFR Part 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

 Not applicable. The State has no such contracts.

Revision: HCFA-PM-94-2 (BPD)
April 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

<p>42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 mentally P.L. 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826</p>	<p>4.24 <u>Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services</u></p> <p>With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.</p> <p><u> </u> Not applicable to intermediate care facilities for the retarded; such services are not provided under this plan.</p>
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TN No. 94-8
Supersedes
TN No. 90-31

Approval Date 6/30/94

Effective Date 4/1/94

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

42 CFR 431.702 AT-78-90	<p>4.25 <u>Program for Licensing Administrators of Nursing Homes</u></p> <p>The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.</p>
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TN No. 759-1

Supersedes

TN No. 759

Approval Date 4/9/74

Effective Date 1/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
1927(g) 42 CFR 456.700	4.26 Drug Utilization Review Program
	A. 1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
1927(g)(1)(A)	2. The DUR program assures that prescriptions for outpatient drugs are: -Appropriate -Medically necessary -Are not likely to result in adverse medical results
1927(g)(1)(a) 42 CFR 456.705(b) and 456.709(b)	B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as: -Potential and actual adverse drug reactions -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug disease contraindications -Drug-drug interactions -Incorrect drug dosage or duration of drug treatment -Drug-allergy interactions -Clinical abuse/misuse
1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: -American Hospital Formulary Service Drug Information -United States Pharmacopeia-Drug Information -American Medical Association Drug Evaluations

TN No. 93-7
Supersedes TN No. 92-19

Approval Date 7/1/93

Effective Date 4/1/93

Revision: HCFA-PM- (MB)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

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- | | | |
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| 1927(g)(1)(D)
42 CFR 456.703(b) | D. | DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

<input checked="" type="checkbox"/> Prospective DUR
<input checked="" type="checkbox"/> Retrospective DUR. |
| 1927(g)(2)(A)
42 CFR 456.705(b) | E. I. | The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient. |
| 1927(g)(2)(A)(i)
42 CFR 456.705(b),
(1)-(7)) | 2. | Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

-Therapeutic duplication
-Drug-disease contraindications
-Drug-drug interactions
-Drug-interactions with non-prescription or over-the-counter drugs
-Incorrect drug dosage or duration of drug treatment
-Drug allergy interactions
-Clinical abuse/misuse |
| 1927(g)(2)(A)(ii)
42 CFR 456.705 (c)
and (d) | 3. | Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles. |
| 1927(g)(2)(B)
42 CFR 456.709(a) | F. I. | The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

-Patterns of fraud and abuse
-Gross overuse
-Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs. |

TN No. 93-7Supersedes TN No. 92-19Approval Date 7/1/93Effective Date 4/1/93

Revision: HCFA-PM- (MB)

Transmittal #93-7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

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- | | | |
|--|-------|--|
| 1927(g)(2)(C)
42 CFR 456.709(b) | F. 2. | The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: <ul style="list-style-type: none"> -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse |
| 1927(g)(2)(D)
42 CFR 456.711 | 3. | The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices. |
| 1927(g)(3)(A)
42 CFR 456.716(a) | G. I. | The DUR program has established a State DUR Board either: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Directly, or <input type="checkbox"/> Under contract with a private organization |
| 1927(g)(3)(B)
42 CFR 456.716
(A) and (B) | 2. | The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: <ul style="list-style-type: none"> - Clinically appropriate prescribing of covered outpatient drugs. - Clinically appropriate dispensing and monitoring of covered outpatient drugs. - Drug use review, evaluation and intervention. - Medical quality assurance. |
| 1927(g)(3)(C)
42 CFR 456.716(d) | 3. | The activities of the DUR Board include: <ul style="list-style-type: none"> - Retrospective DUR, - Application of Standards as defined in section 1927(g)(2)(C), & - ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR. |

TN No. 93-7Approval Date 7/1/93Effective Date 4/1/93Supersedes TN No. 92-19

Revision: HCFA-PM- (MB)

OMB No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)

1927(g)(3)(C) 42 CFR 456.711 (a)-(d)		G. 4	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)		H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	<u>X</u>	I.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i) 42 CFR 456.705(b)	<u>X</u>	2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)		J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this Section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

* U.S. C.P.O.: 1993-342-239:80043

TN #06-08
Supersedes TN #93-7

Approval Date 6/16/06

Effective Date 4/1/06

Revision: HCFA-PM- (MB)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

1902(a)(85) and
Section 1004
Of the SUPPORT Act

K. 1 Claim Review Limitations

Prospective safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.

Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines).

Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis.

Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.

2. Program to Monitor Antipsychotic Medications by children:

Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.

3. Fraud and Abuse Identification:

The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

<p>42 CFR 431.115(c) AT-78-90 AT-79-74</p>	<p>4.27 <u>Disclosure of Survey Information and Provider or Contractor Evaluation</u></p> <p>The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet ail the requirements in 42 CFR 431.115.</p>
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TN No. 79-26

Supersedes

TN No. 74-8

Approval Date 2/6/80

Effective Date 10/1/79

Revision: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.28 Appeals Process

42 CFR 431.152;

AT-79-18

52 F.R. 22444;

Secs. 1902(a)(28)(D)(i)

and 1919(e)(7) of

the Act; P.L.

100-203 (Sec. 4211(c)).

(a) The Medicaid agency has established appeals procedures for

NFs as specified in 42 CFR 431.153 and 431.154.

(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

TN No. 93-12

Supersedes

TN No. 88-26

Approval Date 10/26/93

Effective Date 7/1/93

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

1902(a)(4)(C) of the
Social Security Act
P.L. 05-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the
Social Security Act
P.L. 105-33
1932(d)(3)
42 CFR 438.58

The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

TN #03-13
Supersedes TN #99-13

Approval Date: 11/6/03

Effective Date: 8/13/03

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

Transmittal #88-1
OMB No 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

<p>42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772</p>	<p>4.30 <u>Exclusion of Providers and Suspension of Practitioners and Other Individuals</u></p> <p>(a) All requirements of 42 CFR Part 1002, Subpart B are met.</p> <p>_____ The agency, under the authority of State law imposes broader sanctions.</p>
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TN No. 88-1
Supersedes
TN No. 87-19

Approval Date 2/8/88

Effective Date 1/1/88

HCFA ID: 101OP/0012P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
1902(p) of the Act P.L. 100-93 (secs. 7)	<p>(b) The Medicaid agency meets the requirements of--</p> <p>(1) Section 1902(p) of the Act by excluding from participation--</p> <p>(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).</p>
42 CFR 438.808	<p>(B) An MCO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--</p> <p>(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or</p> <p>(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.</p>
1932(d)(1) 42 CFR 438.610	<p>(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b) suspended, or otherwise excluded from participating in procurement activities under Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c).</p>

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

1902(a)(39) of the Act(2)
P.L. 100-93
(sec. 8(f))

Section 1902(a)(39) of the Act by--

- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
- (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act(2)
P.L. 100-93
(sec. 5(a)(4))
State

Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by licensing authorities in accordance with section 1921 of the Act.

TN No. 88-1
Supersedes
TN No.

Approval Date 2/8/88

Effective Date 1/1/88

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OCTOBER 1987

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L.100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

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OCTOBER 1987

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4-33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN No. 88-1
Supersedes
TN No. 87-19

Approval Date 2/8/88

Effective Date 1/1/88

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

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Citation(s)

1137 of the Act Naturalization P.L. 99-603 (sec. 121)	4.34	<p><u>Systematic Alien Verification for Entitlements</u> The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Service (INS) designated system, Systematic Alien Verification for Entitlements(SAVE), effective October 1, 1988.</p> <p>___ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).</p> <p>___ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.</p> <p>___ Total waiver</p> <p>___ Alternative system</p> <p>___ Partial implementation</p>
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TN No. 88-26

Supersedes

TN No.

Approval Date 1/24/89

Effective Date 10/1/88

HCFA ID: 1010P/0012P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation1919(h)(1)
and (2)
of the ActP.L. 100-203
(Sec 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation.

ATTACHMENT 4.35-A

describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

 Not applicable to intermediate care facilities; these services are not furnished under this plan.X (b) The agency uses the following remedy(ies):
(1) Denial of payment for new admissions.
(2) Civil money penalty.
(3) Appointment of temporary management.
(4) In emergency cases, closure of the facility and/or transfer of residents.1919(h)(2)(B)(ii)
specified
of the ActX (c) The agency establishes alternative State remedies to the Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.1919(h)(2)(F)
of the ActX (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents: (1) Public recognition.X (2) Incentive payments.TN_No. 90-16Approval Date 9/12/90Effective Date 7/1/90

Supersedes TN No.

HCFA ID: 1010P/0012P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.35 Enforcement of Compliance for Nursing Facilities42 CFR
§488.402(f)(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

- (1) nature of noncompliance,
- (2) which remedy is imposed,
- (3) effective date of the remedy, and
- (4) right to appeal the determination leading to the remedy.

42 CFR
§488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR
§488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR
public
§488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies42 CFR
§488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

TN No. 95-15
Supersedes
TN No.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)

	c)	<u>Application of Remedies</u>
42 CFR 488.410	(i)	If there is immediate jeopardy to resident health or safety, The State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
42 CFR §488.417(b) §1919(h)(2)(C) of the Act	(ii)	The State imposes the denial of payment (or its approved alternative) with respect to any Individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
42 CFR 488.414 §1919 (h)(2)(D) of the Act.	(iii)	The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
42 CFR §488.408 1919 (h)(2)(A) of the Act.	(iv)	The State follows the criteria specified at 42 CFR§488.408(c) (2), §488.408(d)(2) and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.
42 CFR §488.412(a)	(v)	When immediate jeopardy does not exist, the State terminate an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.
	(d)	<u>Available Remedies</u>
42 CFR §488.406(b) §1919(h)(2)(A) of the Act.	(i)	The State has established the remedies defined in 42 CFR 488.406(b).
	<input checked="" type="checkbox"/>	(1) Termination
	<input checked="" type="checkbox"/>	(2) Temporary Management
	<input checked="" type="checkbox"/>	(3) Denial of Payment for New Admissions
	<input checked="" type="checkbox"/>	(4) Civil Money Penalties
	<input checked="" type="checkbox"/>	(5) Transfer of Residents; Transfer of Residents with Closure of Facility
	<input checked="" type="checkbox"/>	(6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

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JUNE 1995

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Citation(s)

42 CFR §488.406(b) §1919(h)(2)(B)(ii) of the Act. (ii) The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy Specified in 42 CFR 488.406(b).

- (1)Temporary Management
- (2)Denial of Payment for New Admissions
- (3)Civil Money Penalties
- (4)Transfer of Residents; Transfer of Residents with Closure of Facility
- (5)State monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303(b) 1910(h)(2)(F) of the Act. (e) State Incentive Programs

- (1)Public Recognition
- (2)Incentive Payments

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Effective Date April 1, 1996

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

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Citation(s)

1927(b)(2) (A) of the Act	4.36	The Medicaid Agency complies with all information requirements and reporting provisions specified in 1927(b)(2)(A) of the Social Security Act regarding Medicaid drug rebates.
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TN No. 91-10

Supersedes

TN No.

Approval Date 5/30/91

Effective Date 4/1/91

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)
and 1902(a)(53)
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

TN No. 91-25

Supersedes

TN No.

Approval Date 1/23/92

Effective Date 11/1/91

HCFA ID: 7982E

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

<p>42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28) 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).</p>	<p>4.38</p>	<p><u>Nurse Aide Training and Competency Evaluation for Nursing Facilities</u></p>
	<p>(a)</p>	<p>The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.</p>
	<p><u>X</u></p>	<p>(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).</p>
	<p><u>X</u></p>	<p>(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.</p>
	<p>(d)</p>	<p>The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.</p>
	<p><u>X</u></p>	<p>(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.</p>
	<p><u>X</u></p>	<p>(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.</p>

TN No. 92-8
Supersedes
TN No.

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Effective Date 1/1/92

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- | | |
|--|--|
| <p>42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).</p> | <p>(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.</p> <p>(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.</p> <p>(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.</p> <p>(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.</p> <p>(k) For program reviews other than the initial review, the State visits the entity providing the program.</p> <p>(l) The State does not approve nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).</p> |
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- 42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), or 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).
- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
 - (n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
 - (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
 - (p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
 - X (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
 - (r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

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SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- 42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).
- (s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the state notifies the program in writing, indicating the reasons for withdrawal of approval.
 - (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
 - (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
 - (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
 - (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
 - X (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
 - (y) The State has a standard for successful completion of competency evaluation programs.

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DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

2 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
<u>X</u>	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
(bb)	(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
<u>X</u>	(cc)	The State includes home health aides on the registry.
—	(dd)	The State contracts the operation of the registry to a non State entity.
<u>X</u>	(ee)	<u>ATTACHMENT 4.38</u> contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
<u>X</u>	(ff)	<u>ATTACHMENT 4.38-A</u> contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

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Supersedes

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January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

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Citation(s)

- 1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
- P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).
- 4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities
- (a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).
- (b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.
- (c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.
- (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483-118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.
- X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

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TN No.

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Revision: HCFA-PM-93-1 (BPD)
January 1993

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Citation(s)

4.39 (Continued)

- X (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.
- (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

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TN No.

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APRIL 1992

(HSQB)

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.40 Survey & Certification Process

Sections

1919(g)(1)
thru (2) and 1919(g)(4)
thru (5) of the Act P.L.
100-203(Sec. 4212(a))

(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919 (b), (c) and (d) of the Act, are met.

1919(g)(1)
(B) of the
Act

(b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40A describes the survey and certification educational program.

1919(g)(1)
(C) of the
Act

(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.

1919(g)(1)
(C) of the
Act

(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?

1919(g)(1)
(C) of the
Act

(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

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State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
1919(g)(2) (A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(I), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. <u>Attachment 4.40-C</u> describes the State's procedures.
1919(g)(2) (A)(ii) of the Act	(h)	The state assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of residents assessments and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2) (A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2) (A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2) (B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2) (C) of the Act	(1)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

1919(g)(2) (D) of the Act	(m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. <u>Attachment 4.40-D</u> describes the states program.
1919(g)(2) (E)(i) of the Act	(n) The State uses a multi-disciplinary team of professionals including a registered professional nurse.
1919(g)(2) (E)(ii) of the Act	(o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2) (E)(iii) of the Act	(p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. <u>Attachment 4.40-E</u> describes the State's complaint procedures.
1919(g)(5) (A) of the	(r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5) (B) of the Act	(s) The State notifies the State long-term care ombudsman of the State's findings of noncompliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5) (c) of the Act	(t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5) (D) of the Act	(u) The state provides the State Medicaid fraud and abuse Agency access to all information concerning survey and certification actions.

TN No. 92-16Approval Date 8-12-92Effective Date 4-1-92

Supersedes TN No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.41 Resident Assessment for Nursing Facilities

- | | | |
|--|-----|--|
| Sections
1919(b)(3)
and 1919
(e)(5) of
the Act | (a) | The state specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act. |
| 1919(e)(5)
(A) of the Act | (b) | The State is using:

<u>X</u> the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the <u>State Operations Manual</u>) [§1919(e)(5)(A)]; or |
| 1919(e)(5)
(B) of the Act | — | a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State <u>Medicaid Manual</u> for the Secretary's approval criteria) [§1919(e)(5)(B)]. |

TN No. 92-14

Supersedes

TN No. _____

Approval Date 6-1-92Effective Date 4-1-92

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.42 Employee Education About False Claims Recoveries1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

TN No. 07-02Approval Date 6/19/07Effective Date January 1, 2007

Supersedes TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902 (a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

TN No. 07-02Approval Date 6/19/07Effective Date January 1, 2007

Supersedes TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

TN No. 07-02Approval Date 6/19/07Effective Date January 1, 2007

Supersedes TN No. _____

79aa

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Medical Assistance Program

State/Territory: OREGON

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)

Citation

1902(a)(69) of
The Act,
P.L. 109-171
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts

The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

TN No. 11-05

Supersedes TN No. 11-04

Approval Date: 8/8/11

Effective Date: 7/1/11

79bb

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)

Section 1902(a)
(80) of the ACT,
P.L. 111-148
(Section 6505)

4.44 Medicaid Prohibition on Payments to Institutions or Entities
Located Outside of the United States

The State shall not provide any payments for items or services provided under the State plan or waiver to any financial institution or entity located outside of the United States.

TN No. 11-04
Supersedes TN No.

Approval Date: 5/10/11

Effective Date: 6/1/11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.45 reserved for future use

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)

1902(a)(77)
 1902(a)(39)
 1902(kk)
 P.L. 111-148
 P.L. 111-152

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

42 CFR 455
 Subpart E

PROVIDER SCREENING

Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS

Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under State plan or under waiver of the Plan as a participating provider.

VERIFICATION OF PROVIDER LICENSE

42 CFR 455.412

Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

42 CFR 455.414

REVALIDATION OF ENROLLMENT

Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT

Assures the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials or provider enrollment.

TN No. 12-04

Approval Date: 5/30/12

Effective Date: 4/1/12

Supersedes TN No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)	
42 CFR 455.420	<p>REACTIVATION OF PROVIDER ENROLLMENT</p> <p><input checked="" type="checkbox"/> Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.</p>
42 CFR 455.422	<p>APPEAL RIGHTS</p> <p><input checked="" type="checkbox"/> Assures that all terminated providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.</p>
42 CFR 455.432	<p>SITE VISITS</p> <p><input checked="" type="checkbox"/> Assures the pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.</p>
42 CFR 455.434	<p>CRIMINAL BACKGROUND CHECKS</p> <p><input checked="" type="checkbox"/> Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk fraud, waste or abuse for that category of provider.</p>
42 CFR 455.436	<p>FEDERAL DATABASE CHECKS</p> <p><input checked="" type="checkbox"/> Assures the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.</p>
42 CFR 455.440	<p>NATIONAL PROVIDER IDENTIFIER</p> <p><input checked="" type="checkbox"/> Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim payment that is based on an order or referral of the physician or other professional.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)

- 42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS
 Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
- 42 CFR 455.460 APPLICATION FEE
 Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(J)(2)(C) of the Act and 42 CFRF 455.460.
- 42 CFR 455.470 TEMPORARY MORATORIM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS
 Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 5 PERSONNEL ADMINISTRATION

Citation(s)

5.1 Standards of Personnel Administration

42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

- (a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

_____ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

TN No. 77-6
Supersedes
TN No. 76-6

Approval Date 12/2/77

Effective Date 7/18/77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 5 PERSONNEL ADMINISTRATION

Citation(s)

5.2 [Reserved for future use]

TN No. 80-11

Supersedes
TN No.

Approval Date _____

Effective Date _____

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 5 PERSONNEL ADMINISTRATION

Citation(s)

42 CFR Part 432, Subpart B AT-78-90	5.3 <u>Training Programs; Subprofessional and Volunteer Program</u> The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.
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TN No. 78-2
Supersedes
TN No. 77-6

Approval Date 5/25/78

Effective Date 2/27/78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 6 FINANCIAL ADMINISTRATION

Citation(s)

42 CFR 433.32 AT-79-29	6.1	<p><u>Fiscal Policies and Accountability</u></p> <p>The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.</p>
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TN No. 759-1

Supersedes

TN No. 759

Approval Date 4/9/74

Effective Date 1/1/74

Revision: HCFA-AT-81- (BPP)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 6 FINANCIAL ADMINISTRATION

Citation(s)

6.2 Cost Allocation42 CFR 433.34
47 FR 17490

There is approved cost allocation plans on file with the Oregon Health Authority and the Department of Human Services in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 6 FINANCIAL ADMINISTRATION

Citation(s)

42 CFR 433.33 AT-79-29 AT-80-34	6.3 (a)	<u>State Financial Participation</u> State funds are used in both assistance and administration.
	<u>X</u>	State funds are used to pay all of the non-Federal share of total expenditures under the plan.
	—	There is local participation State funds are used to pay not less than 40 percent of the non-federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.
	(b)	State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

TN No. 759-1

Supersedes

TN No. 759

Approval Date 4/9/74

Effective Date 1/1/74

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #91-25
OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Citation(s)

Citation

7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN No. 91-25

Supersedes

TN No. 759

Approval Date 1/23/92

Effective Date 11/1/91

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #11-01
OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Citation(s)

7.2 Nondiscrimination

45 CFR Parts
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A,

TN No. 11-01

Approval Date: 4/4/11

Effective Date: 6/30/11

Supersedes TN No. 91-25

HCFA ID: 7982E

88

Transmittal #91-25

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Citation(s)

7.3 Maintenance of AFDC Efforts

1902(c) of
the Act

X

The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

TN No. 91-25

Supersedes

TN No. 78-17

Approval Date: 01/23/92

Effective Date: 11/01/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State/Territory: OREGON

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare & Medicaid Services with such documents.

- Not applicable. The Governor--
- Does not wish to review any plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

_____ Oregon Health Authority
(Designated Single State Agency)

Date: 8-8-11

Signature in file
(Signature)

Judy Mohr Peterson, Director
Division of Medical Assistance Program
Oregon Health Authority
(Title)

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by SPA 13-0012

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

- Families with an unemployed parent for 12 months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115

2. Deemed Recipients of AFDC

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

*Agency that determines eligibility for coverage.

TN No. 91-25

Approval Date 1/23/92

Effective Date 11/1/91

Supersedes TN No. 87-41

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	See ACA TN No. 13-0012 in section 8 for partial items removed	
A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)	
	2.	Deemed Recipients of AFDC- Replaced by 13-0012
1902(a)(10)(A)(i)(I) of the Act		b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
402(a)(22)(A) of the Act		c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
406(h) and 1902(a)(10)(A) (i)(I) of the Act	d.	An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
1902(a) of the Act	e.	Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
Supersedes TN No. 90-10 HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3.	Qualified Family Members- Replaced by 13-0012 Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed. — Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.
1902(a)(52) and 1925 of the Act	4.	Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage.

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
Supersedes TN No. 87-40 HCFA ID: 7983E

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AUGUST 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- | | | |
|----------------|----|---|
| 42 CFR 435.113 | 5. | Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are: <ul style="list-style-type: none">a. Families denied AFDC solely because of income and resources deemed to be available from--<ul style="list-style-type: none">(1) Stepparents who are not legally liable for support of stepchildren under a-State law of general applicability;(2) Grandparents;(3) Legal guardians; and(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.c. Families denied AFDC because the family transferred a resource without receiving adequate compensation. |
|----------------|----|---|

*Agency that determines eligibility for coverage-

TN No. <u>91-25</u>	Approval Date <u>1/23/92</u>	Effective Date <u>11/1/91</u>
Supersedes TN No. <u>86-41</u>		HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- | | | |
|---|----|---|
| 42 CFR 435.114 | 6. | Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

<input checked="" type="checkbox"/> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

<input type="checkbox"/> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

<input type="checkbox"/> Not applicable with respect to intermediate care facilities; State did or does not cover this service. |
| 1902(a)(10)
(A)(i)(III)
and 1905(n) of
the Act | 7. | Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her; |

*Agency that determines eligibility for coverage. _____ TN
No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
Supersedes TN No. _____ HCFA ID: 7983E

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

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ATTACHMENT 2.2-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- | | | | | |
|--|----|---|-----|---|
| | 7. | a. | (2) | Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or |
| | | | (3) | Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan. |
| 1902(a)(10)(A)(i)(III) and 1905(n) of the resource Act | b. | Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and requirements of the State's approved AFDC plan. | | |
| | | | — | Children born after

(specify optional earlier date)
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan. |

TN No. 92-5

Approval Date 5/14/92

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act	8.	Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(1)(1)(A) and (B) of the Act. The income level for this group is specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> .
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— The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

1902(a)(10)(A)(i)(VI) 1902(l)(1)(C) of the Act	a.	who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
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1902(a)(10)(A)(i)(VII) and 1902(1)(1)(D) of the Act	b.	born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels. Income levels for these groups are specified in <u>Supplement 1 to ATTACHMENT 2.6A</u> .
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Groups</u> (Continued) <u>Special</u>
		10. Replaced by 13-0012
1902(a)(10) (A)(i)(V) and 1905(m) of the 407 Act	10.	Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
1902(e)(5) of the Act	11. a.	A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b.	A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

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FEBRUARY 1992

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(e)(4) Of the Act (42 CFR 435.117)	12.	Deemed newborns: A child born in the United States to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child's birth, including retroactively. The child is deemed eligible for one year from birth.
42 CFR 435.120	13.	Aged, Blind and Disabled Individuals Receiving Cash Assistance
	<u>X</u>	a. Individuals receiving SSI-
		This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.
	<u>X</u>	Aged
	<u>X</u>	Blind
	<u>X</u>	Disabled

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

435.121	13. —	b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and
1619(b)(1) of the Act		who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(&) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determined eligibility for coverage

TN No. <u>91-25</u>	Approval Date <u>1/23/92</u>	Effective Date <u>11/1/91</u>
Supersedes TN No. <u>87-20</u>		HCFA ID: 7983E

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AUGUST 1991

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State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a) (10)(A) (i)(II) and 1905 (q) of the Act	14.	Qualified severely impaired blind and disabled individuals under age 65, who-- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must-- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled; (2) Except for earnings, continue to meet all non-disability-related requirements for eligibility for SSI benefits; (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determined eligibility for coverage

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
	(4)	Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
	(5)	Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.
	—	Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determined eligibility for coverage

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
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1619(b)(3) of the Act	—	<p>A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)</p> <p>The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.</p>
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*Agency that determined eligibility for coverage

TN No. <u>91-25</u>	Approval Date <u>1/23/92</u>	Effective Date <u>11/1/91</u>
Supersedes TN No. _____		HCFA ID: 7983E

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1634(c) of the Act	15.	Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. ___ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. ___ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
42 CFR 435.122	16.	Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
42 CFR 435.130	17.	Individuals receiving mandatory State-supplements. *Agency that determined eligibility for coverage

TN No. 91-25
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131	18.	Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.
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X In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

X Aged X Blind X Disabled

 Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determined eligibility for coverage

TN No. <u>91-25</u>	Approval Date <u>1/23/92</u>	Effective Date <u>11/1/91</u>
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
42 CFR 435.132	19.	Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
42 CFR 435.133	20.	Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determined eligibility for coverage

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
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<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 C F.R. 435.134	21.	Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972). who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
	<input checked="" type="checkbox"/>	Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).
	<input checked="" type="checkbox"/>	Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
	<input type="checkbox"/>	Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determined eligibility for coverage

TN No. <u>91-25</u>	Approval Date <u>1/23/92</u>	Effective Date <u>11/1/91</u>
Supersedes		
TN No. <u>87-20</u>	HCFA ID:	7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(l) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

— Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

— Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

— The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determined eligibility for coverage

TN No. 91-25

Approval Date 1/23/92

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Supersedes TN No. 87-20

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AUGUST 1991

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<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1634 of the Act	23.	Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act. — Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients. — The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determined eligibility for coverage

TN No. <u>91-25</u>	Approval Date <u>1/23/92</u>	Effective Date <u>11/1/91</u>
Supersedes		
TN No. <u>86-41</u>		HCFA ID: 7983E

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DECEMBER 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
1634(d) of Act	A.	<u>Mandatory Coverage - categorically Needy and Other Required Special Groups (Continued)</u>
	24.	Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.
	—	The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.
	<u>X</u>	In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in Section 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.
	—	In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.
	—	In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

*Agency that determined eligibility for coverage.

TN No. 92-8

Approval Date 5-14-92

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)		
1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act		25. Qualified Medicare Beneficiaries -- <ul style="list-style-type: none"> a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.
1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act		26. Qualified Disabled and Working Individuals -- <ul style="list-style-type: none"> a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed two times the SSI resource limit. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

Revision:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	27.	Specified Low-Income Medicare Beneficiaries -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	28.	Qualifying Individuals -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level; c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

TN No: 10-03
Supersedes TN No. 93-5

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
1634(e) of of the Act	29.	Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of section 1611(e)(4)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

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August 1991

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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See ACA TN No. 13-0012 in section 8 for partial items removed

B. Optional Groups Other Than the Medically Needy

42 CFR
435.210
1902(a)
(10)(A)(ii) and
1905(a) of
the Act

X

1. Individuals described below who meet the income and resources requirements of AFDC, SSI, or an optional state supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

X

The plan covers all individuals as described above.

—

The plan covers only the following group or groups of individuals:

—

Aged

—

Blind

—

Disabled

—

Caretaker relatives-**Removed by 13-0012**

—

Pregnant women- **Removed by 13-0012**

42 CFR
435.211

XX

2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determined eligibility for coverage

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Approval Date 1/23/92

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u> (Continued)
42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)	—	3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in a MCO, PCCM program but who have been enrolled for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C). <input checked="" type="checkbox"/> The State elects not to guarantee eligibility. <input type="checkbox"/> The State elects to guarantee eligibility. The minimum enrollment period is ___ months (not to exceed six). The State measures the minimum enrollment period from: <input type="checkbox"/> The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility. <input type="checkbox"/> The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment. <input type="checkbox"/> The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

*Agency that determined eligibility for coverage

TN #03-13
Supersedes TN #92-8

Approval Date: 11/6/03

Effective Date: 8/13/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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1932(a)(4) of
the Act

B. Optional Groups Other Than the Medically Needy (Continued)

The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of MCOs, PIHPs, PAHPs and PCCMs in accordance with the regulations of 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

No restrictions upon disenrollment rights.

1903(m)(2)(H),
1902(a)(52) of
the Act
P.L. 101-508
(Section 4732)
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with a MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to re-enroll those individuals in the same entity if that entity still has a contract.

The agency elects to re-enroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

The agency elects not to re-enroll above individuals into the same entity in which they were previously enrolled.

*Agency that determined eligibility for coverage

TN No. 04-13

Supersedes TN No. 03-13

Approval Date: 2/10/05

Effective Date: 1/1/05

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u> (Continued)
42 CFR 435.217	<u>X</u>	4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
	<u>X</u>	5. PACE Enrollees.

*Agency that determined eligibility for coverage

TN No. 13-06 Approval Date 7/12/13 Effective Date 4/1/13
Supersedes TN No. 92-8

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AUGUST 1991

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)
(A)(ii)(VII)
of the Act

—

5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

— The State covers all individuals as described above.

— The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
 - 21
 - 20
 - 19
 - 18
- Caretaker relatives
- Pregnant women

*Agency that determined eligibility for coverage

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91

Supersedes

TN No. _____

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Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.220	___ 6.	Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.
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___ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act	___	The State covers only the following group or groups of individuals:
---	-----	---

- ___ Individuals under the age of--
 - ___ 21
 - ___ 20
 - ___ 19
 - ___ 18
 - ___ Caretaker relatives
 - ___ Pregnant woman

435.22 42 CFR 435.2 1902(a)(10)(A)(ii) and 1905(a)(i) of the Act	7. ___ a.	All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below. under the age of 21 as indicated below-
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- ___ 20
- ___ 19
- ___ 18

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222	<u>X</u>	b. Reasonable classifications of individuals described in (a) above, as follows:
	<u>X</u>	(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
age	<u>X</u>	(a) In foster homes (and are under the age of <u>21</u>)
	<u>X</u>	(b) In private institutions (and are under the age of <u>21</u>)
	—	(c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of <u> </u>).
	—	(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of <u> </u>)
	<u>X</u>	(3) Individuals in NFs (who are under the age of <u>21</u>). NF services are provided under this plan.
	<u>X</u>	(4) In addition to the group under (b)(3), individuals in ICFS/MR (who are under the age of <u>21</u>)

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AUGUST 1991 Page 13a ATTACHMENT 2.2-A

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Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

B. Optional Groups Other Than the Medically Needy (Continued)

X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

X (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91

Supersedes

TN No. _____

HCFA ID: 7983E

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Agency* Citation(s) Groups Covered

Page replaced by 13-0012

B. Optional Groups Other Than the Medically Needy (Continued)

I902(a)(10)
(A)(ii)(VIII)
of the Act

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

approved

- a. Was eligible for Medicaid under the State's Medicaid plan; or
- b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

— 21
— 20
— 19
 18

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Supersedes TN No. 86-41

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Agency* Citation(s) Groups Covered

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B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.223	—	9.	Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
1902(a)(10)	—		Individuals under the age of--
(A)(ii) and	—		— 21
1905(a) of	—		— 20
the Act	—		— 19
	—		— 15
	—		Caretaker relatives
	—		Pregnant women

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230	—	10. <u>States using SSI criteria with agreements under sections 1616 and 1634 of the Act.</u>
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The following groups of individuals who receive only a state supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
 - (1) All aged individuals.
 - (2) All blind individuals.
 - (3) All disabled individuals.

*Agency that determined eligibility for coverage

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

	(4)	Aged individuals in domiciliary facilities or other group living.
42 CFR 435.230	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	(7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	(8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	(9)	Individuals in additional classifications approved by the Secretary as follows:

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Supersedes
TN No. 86-41 HCFA ID: 7983E

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes.

No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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Supersedes

TN No. _____

HCFA ID: 7983E

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Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR ~~435.120~~
435.121
1902(a)(10)
(A)(ii)(XI)
of the Act

X 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:
 - X (1) All aged individuals.
 - X (2) All blind individuals.
 - X (3) All disabled individuals.

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Supersedes TN No. 87-20 HCFA ID: 7983E

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AUGUST 1991

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

- | | | |
|----------|-----|---|
| <u>X</u> | (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| <u>X</u> | (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| <u>X</u> | (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (7) | Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| <u>X</u> | (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (9) | Individuals in additional classifications approved by the Secretary as follows: |

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91

Supersedes

TN No. 91-17

HCFA ID: 7983E

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91

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TN No. _____

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Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231 X 12. Individuals who are in institutions for at least 30 consecutive
1902(a)(10) days and who are eligible under a special income level.
(A)(ii)(V) Eligibility begins on the first day of the 30-day period.
of the Act These individuals meet the income standards specified in
Supplement 1 to ATTACHMENT 2.6-A.

— The State covers all individuals as described above.

X The State covers only the following group or groups of
individuals:

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

X Aged
X Blind
X Disabled
— Individuals under the age of--
— 21
— 20
— 19
— 18
— Caretaker relatives
— Pregnant women

TN No. 91-25

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Agency*	Citation(s)	Groups Covered
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See ACA TN No. 13-0012 in section 8 for partial items removed

B. Optional Groups Other Than the Medically Needy (Continued)

1902(e)(3) of the Act	—	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.
--------------------------	---	--

Supplement 3 to ATTACHMENT 2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

14. Replaced by 13-0012

1902(a)(10) (A)(ii)(IX) and 1902(1) mandatory of the Act	<u>X</u>	14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6--A</u> : <ul style="list-style-type: none"> a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)
(10)(A)
(ii)(IX)
and 1902(l)(l)
(D) of the Act

X

15. The following individuals who are not mandatory categorically needy who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of Attachment 2.6-A for a family of the same size.

Children who have attained 6 years of age but have not attained age 19.

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AUGUST 1991

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)
(ii)(X)
and 1902(m)
(1) and (3)
of the Act

- ___ 16. Individuals--
- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both and disabled individuals are covered under this aged eligibility group.
 - b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
 - c. Whose resources do not exceed the maximum -amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

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Supersedes TN No. _____

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HCFA ID: 7983E

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

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Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(47)
"qualified
and 1920 of
the Act

- 17. Pregnant women who are determined by a provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

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OCTOBER 1991

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OMB NO.:

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

1906 of the
Act

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 1 months.

1902(a)(10)(F)
and 1902(u)(1)
of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

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Supersedes TN No. _____ HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
1902(a)(10)(A) [X] (ii)(XIII) of the Act	20.	<p>BBA Work Incentives Eligibility group- Working Disabled individuals whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.</p>
1902(a)(10)(A) [X] (ii)(XVIII) of the Act	21.	<p>Women who:</p> <ul style="list-style-type: none"> a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under XV of the Public Health Service Act in accordance with the requirements of section 15 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix; b. are not otherwise covered under creditable coverage, as defined in section 2701(c) the Public Health Service Act; c. are not eligible for Medicaid under any mandatory categorically needy eligibility growth and d. have not attained age 65.

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Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012 in section 8

B. Optional Groups Other Than the Medically Needy (Continued)

1920B of the Act [X] 22. Women who are determined by a "qualified entity" (as defined in 1920B(b) based on preliminary information, to be a woman described in 1(aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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B. Optional Coverage Other Than the Medically Needy
(Continued)

1902(e)(12) of the Act	<u>X</u> 23.	Continuous Eligibility for Children. A child under age <u>19</u> (not to exceed age 19) who has been determined eligible under §1902(a)(10)(A) of the Act is deemed to be eligible for a total of <u>12</u> months (not to exceed 12 months) regardless of changes in circumstances, other than moving out of the State or attainment of the maximum age stated above, until the earlier of: a. The end of a period (not to exceed 12 months) of continuous eligibility; or b. The time that the individual exceeds that age.
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

MACPro submission

B. Optional Coverage Other Than the Medically Needy (Continued)-

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends. The 12-month postpartum continuous eligibility option applies for the period beginning on the effective date of this reviewable unit and is available through March 31, 2027 (or other date as specified by law).

Yes

No

1. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.
2. Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for an individual described in subsection 1902 (a)(10)(A)(i) of the Act.

TN No. 22-0008 Approval Date: 5/25/22

Effective Date: 4/1/22

Supersedes TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

MACPro submission

B. Optional Coverage Other Than the Medically Needy (Continued)-MACpro filing

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

3. Continuous eligibility is provided to pregnant individuals eligible and enrolled under the state plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:
 - a. The individual requests voluntary termination of eligibility;
 - b. The individual ceases to be a resident of the state;
 - c. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the individual; or
 - d. The individual dies.
- C. Additional Information (optional)

TN No. 22-0008 Approval Date: 5/25/22 Effective Date: 4/1/22
Supersedes TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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Page replaced by 13-0012 in section 8

Sections 477, 1902(a)(10)(A)(ii)(XVII), and 1905(w) of the Act	B. <u>Optional Groups Other Than the Medically Needy</u> (Continued) 24. Independent Foster Care Adolescents. An individual who is younger than age 21, who on the individual's 18 th birthday was in foster care under the responsibility of a State, who meets the targeting criteria in a.) below, and whose income and resources do not exceed the level(s), if any, established in b.) below. a. Individuals who meet the following criteria: 1) Are under the age of: <input checked="" type="checkbox"/> 21 <input type="checkbox"/> 20 <input type="checkbox"/> 19 2) Are: <input checked="" type="checkbox"/> All such individuals. <input type="checkbox"/> Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old. <input type="checkbox"/> Other reasonable classifications: b. Financial requirements 1) Income test: <input checked="" type="checkbox"/> There is no income test. <input type="checkbox"/> The income test is: 2) Resource test: <input checked="" type="checkbox"/> There is no resource test. <input type="checkbox"/> The resource test is:	
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Note: If there is an income or resource test, the standards and methodologies may not be more restrictive than those for the State's section 1931 population, as specified in Supplement 12 of Attachment 2.6-A.

TN No. 10-04

Approval Date 5/18/10

Effective Date 5/1/10

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGONGROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	C.	<u>Optional Coverage of the Medically Needy</u>
42 CFR 435.301		This plan includes the medically needy.
	<input checked="" type="checkbox"/>	No.
	<input type="checkbox"/>	Yes. This plan covers:
	1.	Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
1902(e) of the Act	2.	Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
1902(a)(10) (C)(ii)(I) of the Act	3.	Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a) (10) (A)(i) of the Act.

TN No. 03-04

Approval Date 03/11/03

Effective Date 02/01/03

Supersedes TN No. 02-14

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #09-06
ATTACHMENT 2.2-A
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OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<u>Agency*</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
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C. Optional Coverage of the Medically Needy (Continued)

42 CFR 435.308

4. (left blank intentionally)

5. a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--
 — 21
 — 20
 — 19
 — 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

 b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

 (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

 (a) In foster homes (and are under the age of 21).

 (b) In private institutions (and are under the age of 21).

TN No. 09-06

Date Approved: 7/31/09

Effective Date 07/1/09

Supersedes TN No. 03-04

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #03-04
ATTACHMENT 2.2-A

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	C.	<u>Optional Coverage for the Medically Needy (Continued)</u>
		— (c) In addition to the group under b.(l)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).
		— (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).
		— (3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.
		— (4) In addition to the group under (b)(3), individuals in ICF9/MR (who are under the age of ___).
		— (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of). Inpatient-psychiatric services for individuals under age 21 are provided under this plan.
		— (6) Other defined groups (and ages), as specified in Supplement 1 of <u>ATTACHMENT 2.2-A</u> .

TN No. 03-04

Approval Date 03/11/03

Effective Date 02/01/03

Supersedes TN No. 02-14

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #03-04
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OMB NO.: 0938

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
	C.	<u>Optional Coverage for the Medically Needy (Continued)</u>
42 CFR 435.310	—	6. Caretaker Relatives
42 CFR 435.320 and 42 CFR 435.330	—	7. Aged Individuals
42 CFR 435.322 and 42C FR 435.330	—	8. Blind Individuals
42 CFR 435.324 and 42 CFR 435.330	—	9. Disabled Individuals
42 CFR 435.326	—	10. Individuals who would be eligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
42 CFR 435.340	11.	Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as-medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

TN No. 03-04

Approval Date 03/11/03

Effective Date 02/01/03

Supersedes TN No. 02-14

HCFA ID: 7983E

Revision: HCFA-PM-91-8 (BPD)
October 1991

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OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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C. Optional Coverage for the Medically Needy (Continued)

1906 of the
Act

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of __ months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
	1935(a) and 1902(a)(66)	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
	42 CFR 423.774 and 423.904	<ol style="list-style-type: none">1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

TN No. 05-06

Approval Date August 18, 2005

Effective Date July 1, 2005

Supersedes TN No. _____

Revision: HCFA-PM-91-4 (BPD) Transmittal #92-4
AUGUST 1991 Page 1 SUPPLEMENT 1 TO ATTACHMENT 2.2-A
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

Page replaced by 13-0012 in section 8

- 7.b(6) Other defined groups:
1. Individuals making a transition from foster care to independent living arrangements (who are under 21 years of age), with all or part of their maintenance costs paid by a public agency of this state.
 2. Individuals under age 21 who are essential persons under the AFDC state plan.

TN No. 92-4 Approval Date 4/28/92 Effective Date 1/1/92
Supersedes TN No. 91-25 HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD) Transmittal #91-25
AUGUST 1991 Page 1 SUPPLEMENT 3 TO ATTACHMENT 2.2-A
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Method for Determining Cost Effectiveness of Caring for
Certain Disabled Children At Home

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
Supersedes TN No. _____ HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
A.	<u>General Conditions of Eligibility</u>
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, subpart F	2. a(i) &(iii) replaced by 13-0012 2. Meets the applicable non-financial eligibility conditions. a. For the categorically needy: (i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program. (ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A) (i)(IV), 1902(a)(10)(A)(i) (VI), 1902(a)(10)(A)(i) (VII), and 1902(a)(10)(A)(ii) (IX) of the Act, meets the non-financial criteria of section 1902(1) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	Replaced by ACA TN No. 13-0017 in section 8 (partial)
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(8).
42 CFR 435.406	<p>13-0017, form S89 replaced 3.</p> <p>3. Is residing in the United States (U.S.),and--</p> <p>a. Is a citizen or national of the United States;</p> <p>b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;</p> <p>c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)

Condition or Requirement

Page replaced by 13-0017, form S89 in section 8

- d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
- e. Is a qualified alien (QA) whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.
 State covers all authorized QAs.
 State does not cover authorized QAs.
- f. State elects CHIPRA option to provide full Medicaid coverage to all otherwise eligible alien pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:
 - (1) A "Qualified alien" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
 - (2) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Page replaced by 13-0017, form S89 in section 8

- (3) An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:
 - (a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
 - (b) An individual currently under Temporary Protected Status pursuant to section 244 of the INA;
 - (c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;
 - (d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and
 - (e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and
- (4) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:
 - A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;
 - A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;
 - A religious worker under section 101(a)(15)(R);
 - An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;
 - A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and
 - An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA.

Elected for pregnant women.
 Elected for children under age 19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Page replaced 13-0017, form S89 in section 8

g. X The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the ~~Act~~.

Revision: HCFA-PM-91-4 (MB)
AUGUST 1991

Transmittal #02-08
ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Page replaced by 13-0016, form S88

A. General Conditions of Eligibility (continued)

42 CFR 435.403
individual
1902(b) of the
Act

4. Is a resident of the State, regardless of whether or not the
maintains the residence permanently or maintains it at a fixed
address.

State has Interstate Residency Agreement with the
following States:

State has open agreement(s).

Not applicable; no residency requirement.

TN # 02-08 Approval Date 8/20/02
Supersedes TN # 91-25

Effective Date 7/1/02

HCFA ID: 7985E

Revision: HCFA-PM-91-8
October 1991

(MB)

Transmittal #92-3
ATTACHMENT 2.6-A
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OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.1008 do	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. — Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 435.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

TN No: 92-3

Approval Date 4/8/92

Effective Date 1/1/92

Supersedes TN No. 91-25

HCFA ID: 7985E

Revision: HCFA-PM-91-8 (MB)
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Transmittal #14-06
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number) except for aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137(f)).
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TN No: 14-06 Approval Date 7/21/14
Supersedes TN No. 92-3

Effective Date 7/1/14
HCFA ID: 7985E

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AUGUST 1991

Transmittal #91-25
ATTACHMENT 2.6-A

Page 3b

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Page replaced by 13-0012

1902(c)(2)	8. Is not required to apply for AFDC benefits under title TV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A)9. and (B) of the Act	Is not required, as an individual child or pregnant woman; to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

TN No: 91-25 Approval Date 1/23/92

Effective Date 11/1/91

Supersedes TN No. _____

HCFA ID: 7985E

Revision: HCFA-PM-91-8 (MB)
October 1991

Transmittal #92-3
ATTACHMENT 2.6-A
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OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

TN No: 92-3 Approval Date 4/8/92
Supersedes TN No. _____

Effective Date 1/1/92
HCFA ID: 7985E

Revision: HCFA-PM-97-2
December 1997

Transmittal #98-05
ATTACHMENT 2.6-A
Page 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	B. Post-eligibility Treatment of Institutionalized Individual's Income
	1. The following items are not considered in the post-eligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and(G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension(reparation) payments under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparation Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P.L. 100-383	d. Japanese and Aleutian Restitution Payments.
1.(a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P.L. 103-66	h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

TN No: 98-05

Approval Date 6/18/98

Effective Date 1/1/98

Supersedes TN No. 91-25

Revision: HCFA-PM-02-1
May 2002

Transmittal # 14-03
ATTACHMENT 2.6-A
Page 4a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<u>1924</u> of the Act 435.725 435.733 435.832	<p>2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutional care:</p> <p>Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.</p> <p>a. Aged, blind, disabled: Individuals \$ <u>60.00</u> Couples \$ <u>120.00</u></p> <p>*Periodically adjusted based upon SSA COLA increases.</p> <p>For the following individuals with greater need: Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the authority for approving that a criterion is met.</p> <p>b. AFDC related: Children \$ <u>30.00</u> Adults \$ <u>30.00</u></p> <p>For the following individuals with greater need: Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the authority for approving that a criterion is met.</p> <p>c. Individuals under age 21 covered in this plan as specified in Item B.7. of <u>ATTACHMENT 2.2-A</u>. N/A</p>

Revision: HCFA-PM-97-2
December 1997

Transmittal #98-05
ATTACHMENT 2.6-A
Page 4b

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	For the following individuals with greater need: Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the authority for approving that a criterion is met.
1924 of the Act	<p>3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:</p> <p>a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</p> <p><input checked="" type="checkbox"/> The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</p> <p><input type="checkbox"/> The poverty level component is calculated using a percentage greater than the applicable percentage, equal to %, of the official poverty level (still subject to maximum maintenance needs standard.)</p> <p><input type="checkbox"/> The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).</p> <p>Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.</p>

TN No: 98-05 Approval Date 6/18/98

Effective Date 1/1/98

Supersedes TN No.

Revision: HCFA-PM-97-2
December 1997

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	In determining any excess shelter allowance, utility expenses are calculated using: <input checked="" type="checkbox"/> the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or <input type="checkbox"/> the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.
b.	The monthly income allowance for other dependent family members living with the community spouse is: <input checked="" type="checkbox"/> one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income. <input type="checkbox"/> a greater amount calculated as follows: The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1).
c.	Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party. (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplemental 3 to <u>ATTACHMENT 2.6-A.</u>)

TN No: 98-05
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Approval Date 6/18/98

Effective Date 1/1/98

Revision: HCFA-PM-97-2
December 1997

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
435.725 435.733 435.832	<p>4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</p> <ul style="list-style-type: none">• AFDC level; or• Medically need level: <p>(Check one)</p> <p style="padding-left: 40px;"><input type="checkbox"/> AFDC levels in Supplement 1</p> <p style="padding-left: 40px;"><input checked="" type="checkbox"/> Medically needy level in Supplement 1</p> <p style="padding-left: 40px;"><input type="checkbox"/> other: \$</p> <p>b. Amounts for health care expenses described below that have not been deducted under 3..c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, are not subject to payment by a third party.</p> <p>(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</p> <p>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to <u>ATTACHMENT 2.6-A</u>.)</p>
435.725 433.733 433.832	<p>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an Institutionalized couple:</p> <p>A monthly amount for the maintenance of the home of the individual couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</p> <p style="padding-left: 40px;"><input type="checkbox"/> No</p> <p style="padding-left: 40px;"><input checked="" type="checkbox"/> Yes (the applicable amount is shown on page 5a.)</p>

TN No: 98-05
Supersedes TN No. 93-05

Approval Date 6/18/98

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Transmittal #98-05
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OMB No.: 0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<u> </u>	Amount of maintenance of home is: \$_____.
<u> </u>	Amount of maintenance of home is the actual maintenance costs not to exceed \$_____.
<u> </u>	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
<u> </u>	Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.
<u> X </u>	Amount for maintenance of home is the actual maintenance costs, no upper limit.

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FEBRUARY 1992

(MB)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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13-0012 removed AFDC recipients, pregnant women, infants and children from this page.

42 CFR 435.711
435.721, 435.831

c. Financial Eligibility

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10) (A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a) (10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

TN No: 92-5
Supersedes TN No.

Approval Date 5-14-92

Effective Date 1-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<u>X</u>	<u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
—	<u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
—	<u>Supplement 4 to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
—	<u>Supplement 5 to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
—	<u>Supplement 8a to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.
<u>X</u>	<u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.
—	<u>Supplement 14 to ATTACHMENT 2.6-A</u> specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) Condition or Requirement

13-0012 removed 1. A.(1) and (2) from, this page.

1902(r)(2)
of the Act

1. Methods of Determining Income

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable income for AFDC-related individuals, the following methods are used:

X (a) The methods under the State's approved AFDC plan only; or

(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

1902(e)(6)
the Act

(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

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Supersedes TN No.

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FEBRUARY 1992

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B) (m)(4) and 1902 (r)(2) of the Act	b. <u>Aged individuals</u> . In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: <input type="checkbox"/> The methods of the SSI program only. <input checked="" type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

TN No: 08-07

Approval Date 7/3/08

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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<u> </u>	For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<u> X</u>	For institutional couples, the methods specified under section 1611(e)(5) of the Act.
<u> </u>	For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
<u> X</u>	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
<u> X</u>	SSI methods only.
<u> </u>	SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<u> </u>	Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

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AUGUST 1991

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. <u>Blind individuals.</u> In determining countable income for blind individuals, the following methods are used:
	<input type="checkbox"/> The methods of the SSI program only.
	<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<input type="checkbox"/> For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> , and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<input checked="" type="checkbox"/> For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	<input type="checkbox"/> For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<input checked="" type="checkbox"/> For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	<input checked="" type="checkbox"/> SSI methods only.
<input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>	
<input type="checkbox"/> Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>	

TN No: 08-07
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Approval Date 7/3/08

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AUGUST 1991

(BPD)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)

Condition or Requirement

In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

42 CFR 435.721,
and 435.831
1902(m)(1)(B),
(m)(4), and
1902(r)(2) of
the Act

d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:

The methods of the SSI program.

SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

For institutional-couples: the methods specified under section 1611(e)(5) of the Act.

For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

TN No: 08-07

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<u>X</u>	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
<u>X</u>	SSI methods only.
—	SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to Attachment 2.6-A</u>
—	Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

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Effective Date 11/1/91
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Page replaced by 13-0012

1902(l)(3)(E)
and 1902(r)(2)
of the Act

e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--

(1) The following methods are used in determining countable income:

X The methods of the State's approved AFDC plan.

— The methods of the approved title IV-E plan.

— The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

— The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

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Supersedes TN No. 91-25

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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13-0012 removed (2) from this page

- | | |
|---|--|
| | (2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21. |
| 1902(e)(6) of the Act | (3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls. |
| 1905(p)(1),
1902(m)(4),
and 1902(r)(2) of the Act | f. <u>Qualified Medicare beneficiaries</u> . In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:

— The methods of the SSI program only.

<u>X</u> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

<u>X</u> For institutional couples, the methods specified under section 1611(e)(5) of the Act. |

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	<p>If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.</p> <p>For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.</p> <p>For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.</p>
1905(s) of the Act	<p>g. (1) <u>Qualified disabled and working individuals.</u></p> <p>In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) Of the Act, the methods of the SSI program are used.</p>
1905(p) of the Act	<p>(2) <u>Specified low-income Medicare beneficiaries.</u></p> <p>In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.</p>

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Approval Date 7/2/93

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Supersedes TN No. 92-5

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OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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1902(u)
of the Act

(h) COBRA Continuation Beneficiaries

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

- ___ The disregards of the SSI program;
- ___ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(a)(10)(A)(i) (ii)(XIII) of the Act	<p><u>Working Disabled Who Buy Into Medicaid</u></p> <p>In determining countable income and resources for Working Disabled individuals who buy into Medicaid, the following methodologies are applied:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methodologies of the SSI program.<input type="checkbox"/> The agency uses methodologies for the treatment of income and resources more restrictive than the SSI Program. These more restrictive methodologies are described in Supplement 4 to attachment 2.6-A.<input checked="" type="checkbox"/> The agency uses more liberal income and/or resource methodologies than the SSI Program. More liberal income methodologies are described in Supplement 8a to attachment 2.6-A. More liberal resource methodologies are described in Supplement 8a to attachment 2.6-A.<input checked="" type="checkbox"/> The agency requires individuals to pay premium or other cost sharing charges, known as a participant liability. The premium or other cost sharing charges, and how they are applied, are described in attachment 2.6-A, page 12d.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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ESTABLISHMENT AND APPLICATION OF A PREMIUM
OR OTHER COST SHARING CHARGES

Section 1902(f) State

Non-Section 1902(f) State

1. Any Working Disabled individual who receives Medicaid benefits shall be subject to cost sharing. The following premium or cost sharing procedures shall be utilized:

The Working Disabled participant liability shall be based on a sliding fee scale, determined by the client's monthly earned and unearned income.

- For clients with income below 75% of the Federal Poverty Level (FPL), the monthly participant liability will be \$0.
- For clients with income between 75% and 100% of the FPL, the monthly participant liability will be \$50.
- For clients with income between 101% and 250% of the FPL, the monthly participant liability will be \$100.
- For clients with income above 250% of the FPL, the monthly participant liability will be \$150. This calculation will be based on countable income. Eligibility for the program is determined by adjusted income. No client with adjusted income above 250% of FPL will be eligible for the program.

Failure by the client to pay the participant liability shall result in ineligibility for the client in the Working Disabled program.

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AUGUST 1991

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OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(k) of the Act	<p>2. Medicaid Qualifying Trusts</p> <p>In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted-under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally-retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p>— The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p>3. Medically needy income levels (MNILs) are based on family size.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR.435.732, 435.831	<p>4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only</p> <p>a. <u>Medically Needy</u></p> <p>(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of ___ month (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.</p> <p>(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:</p> <p>(a) Health insurance premiums, deductibles and coinsurance charges.</p> <p>(b) Expenses for necessary medical and remedial care not included in the plan.</p> <p>(c) Expenses for necessary medical and remedial care included in the plan.</p> <p>___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.</p> <p>1902(a)(17) of the Act</p> <p>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.</p>

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Citation(s)	Condition or Requirement
1903(f)(2) of the Act	a. Medically Needy (Continued) — (3) If countable income exceeds the MNIL standard, the agency deducts spend down payments made to the State by the individual.

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Citation(s)	Condition or Requirement
42 CFR 435.732	<p>b. Categorically Needy - Section 1902(f) States</p> <p>The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol style="list-style-type: none">(1) Any SSI benefit received.(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.(3) Increases in OASDI that are deducted under §435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.(4) Other deductions from income described in this plan at <u>Attachment 2.6-A. Supplement 4</u>.(5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	<p>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.</p>

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	4.b. <u>Categorically Needy - Section 1902(f) States</u> -Continued
1903(f)(2) of Act	— (6) Spend down payments made to the State by the individual.

NOTE: FFP will be reduced to the extent a State is paid a spend down payment by the individual.

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Citation(s)	Condition or Requirement
5.	<u>Methods for Determining Resources</u>
	a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u>
	(1) In determining countable resources for AFDC-related individuals, the following methods are used:
	(a) The methods under the State's approved AFDC plan; and
	____(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
	(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

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5. Methods for Determining Resources

1902(a)(10)(A),
1902(a)(10)(C),
1902(m)(1)(B)
and (C), and
1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

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Citation(s)	Condition or Requirement
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In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A),
1902(a)(10)(C),
1902(m)(1)(B), and
1902(r) of the
Act

- c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources:
- The methods of the SSI program.
 - SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
 - Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

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Citation(s)	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program.<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u><input type="checkbox"/> Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(l)(3) and 1902(r)(2) of the Act	<p>13-0012 removed e.</p> <p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program only.<input type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in Supplement 5a of Supplement 8b to ATTACHMENT 2.6-A.

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Effective Date 11/1/91
HCFA ID: 7985E

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	<p style="text-align: center;">Page replaced by 13-0012</p> <p><input type="checkbox"/> Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility.</p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
<p>1902(l)(3) and 1902(r)(2) of the Act</p>	<p>f. <u>Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <p><input type="checkbox"/> The methods of the State's approved AFDC plan.</p> <p><input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p>
<p>1902(1)(3)(C) of the Act</p>	<p><input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>
<p>1902(r)(2) of the Act</p>	<p><input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility.</p>

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	Page replaced by 13-0012 in section 8
1902(l)(3) and 1902(r)(2) of the Act	<p>g. 1. <u>Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the State's approved AFDC plan.
1902(l)(3)(C) State's of the Act	<ul style="list-style-type: none"><input type="checkbox"/> Methods more liberal than those in the approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(r)(2) State's of the Act	<ul style="list-style-type: none"><input type="checkbox"/> Methods more liberal than those in the approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
	<ul style="list-style-type: none"><input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility. <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21</p>

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	Page was replaced by 13-0012 in section 8
1902(l)(3) and 1902(r)(2) of the Act	<p>g. 2. <u>Poverty level children under section 1902(a)(10)(A)(i)(VII)</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the State's approved AFDC plan.
1902(l)(3)(C) the Act	<ul style="list-style-type: none"><input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 8a of ATTACHMENT 2.6-A.</u>
1902(r)(2) of the Act	<ul style="list-style-type: none"><input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u><input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility.

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. <u>For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act</u> the agency uses the following methods for treatment of resources: — The methods of the SSI program only. <u>X</u> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: — The methods of the SSI program only. — More restrictive methods applied under section 1902(f) of the Act as described in <u>Supplement 5 to Attachment 2.6-A.</u>

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Citation(s)	Condition or Requirement
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6. Resource standard - Categorically Needy

- a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

— Same as SSI resource standards.

— More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

- b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

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Citation(s)	Condition or Requirement
	Page was replaced by 13-0012 in section 8
1902(1)(3)(A) provisions (B) and (C) of the Act	<p>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>
1902(l)(3)(A) and (C) of the Act	<p>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (D) of the Act	<p>e. For children covered under the provisions of section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>

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Citation(s)	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	<p>f. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(x) of the Act, the resource standard is:</p> <ul style="list-style-type: none"> — Same as SSI resource standards. — Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). <p><u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for these individuals.</p>

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Citation(s)	Condition or Requirement
1902(a)(10)(C)(i) of the Act	<p>7. Resource Standard - Medically Needy</p> <p>a. Resource standards are based on family size.</p> <p>b. A single standard is employed in determining resource resource eligibility for all groups.</p> <p><input type="checkbox"/> c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--</p> <p><input type="checkbox"/> Aged</p> <p><input type="checkbox"/> Blind</p> <p><input type="checkbox"/> Disabled</p> <p><u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., <u>Supplement 2 to ATTACHMENT 2.6-A</u> so indicates.</p>
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	<p>8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals</p> <p>For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.</p>

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.
1902(u) of the Act	9.1. For COBRA continuation beneficiaries, the resource standard is: ___ Twice the SSI resource standard for an individual. ___ More restrictive standard as applied under section 1902(f) of the Act as described in <u>Supplement 8 to Attachment 2.6-A</u> .

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
10.	Excess Resources
a.	Categorically Needy, Qualified Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible.
b.	Categorically Needy Only — This state has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.
c.	Medically Needy Any excess resources make the individual ineligible.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR	11. Effective Date of Eligibility
435.914	a. Groups Other Than Qualified Medicare beneficiaries
	(1) For the prospective period. Coverage is available for the full month if the following individuals are eligible at any time during the month. <u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related. <u>X</u> MAGI. Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements. <u> </u> Aged, blind, disabled. <u> </u> AFDC-related. <u> </u> MAGI.
	(2) For the retroactive period. Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied: <u> </u> Aged, blind, disabled. <u> </u> AFDC-related. <u> </u> MAGI. Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied. <u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related. <u>X</u> MAGI

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	13-0012 removed (3) on this page
1920(b)(1) of the Act	<p><u>—</u> (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in <u>ATTACHMENT 2.6-A</u> of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</p>
1902(e)(8) and section 1905(a) of the Act	<p><u>X</u> b. For qualified Medicare beneficiaries defined in 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--</p> <p><u>X</u> 12 months <u>—</u> 6 months <u>—</u> <u> </u> months (no less than 6 months and no more than 12 months)</p>

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Citation(s)	Condition or Requirement
<u>_1902(a)(18)</u> and <u>1902(f)</u> of the Act	12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A.</u>
1917(c)	13. Transfer of Assets - All eligibility groups The agency complies with the provisions of section 1917 (c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to ATTACHMENT 2.6-A</u> , except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14. Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917 (d) of the Act, as amended by OBRA 93, with regard to trusts. <input type="checkbox"/> The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts; <input checked="" type="checkbox"/> The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of <u>Miller</u> trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 10 to ATTACHMENT 2.6-A.</u>

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Citation(s)	Condition or Requirement
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1924 of the Act

15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

the maximum standard permitted by law;

the minimum standard permitted by law; or

a standard that is an amount between the minimum and the maximum.

TN No: 99-02 Approval Date 7/1/99

Effective Date 4/1/99

Supersedes TN No. 98-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) Condition or Requirement

Page replaced by 13-0012 in section 8

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<u>Family Size</u>	<u>Need Standard</u>	<u>Payment Standard</u>	<u>Maximum Payment Amounts</u>
1	\$ 345	\$ 310	\$ 310
2	499	395	395
3	616	460	460
4	795	565	565
5	932	660	660
6	1,060	755	755
7	1,206	840	840
8	1,346	925	925
9	1,450	985	985
10	1,622	1,090	1090
Each Additional Person	172	105	105

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level--

133 percent

____ percent (no more than 185 percent)

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #04-04
SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 2
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Page replaced by 13-0012 in section 8

INCOME ELIGIBILITY LEVELS (continued)

A. MANDATORY CATEGORICALLY NEEDY (continued)

3. Children under Section 1902(a)(10)(i)(VI) of the Act who have attained age 1 but have not attained age 6:

Effective April 1, 1990, based on 133 percent of the official Federal income poverty level.

TN No. 04-04

Approval Date 3/25/04

Effective Date 2/13/04

Supersedes TN No. 03-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Page replaced by 13-0012 in section 8

INCOME ELIGIBILITY LEVELS (continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on up to 185 percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #04-04
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Page replaced by 13-0012 in section 8
INCOME ELIGIBILITY LEVELS (continued)

B. MANDATORY CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 19

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age under the provisions of Sections 1902(1)(2) and 1902(a)(10)(A)(i)(VII) of the Act are as follows:

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line.

TN No. 04-04

Approval Date 3/25/04

Effective Date 2/13/04

Supersedes TN No. 03-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Replaced by ACA TN No. 13-0012 in section 8
INCOME ELIGIBILITY LEVELS (continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 19

The levels for determining income eligibility for groups of children who have attained 6 years of age, but not age 19, under the provisions of section 1902(1)(1) of the Act are as follows:

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
1	\$ 748
2	1,010
3	1,272
4	1,533
5	1,795
6	2,057
7	2,318
8	2,580
9	2,842
10	3,103

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

Transmittal #92-5
SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) Condition or Requirement

INCOME ELIGIBILITY LEVELS (continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on ____ percent of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
1	\$
2	\$
3	\$
4	\$
5	\$

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

TN No. 92-5

Approval Date 5-14-92

Effective Date 1-1-92

Supersedes TN No. 91-25

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #04-05
SUPPLEMENT 1 TO ATTACHMENT 2.6-A
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OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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INCOME ELIGIBILITY LEVELS (continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The level for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of Section 1905(p)(2)(A) of the Act are as follows:

1. Non-Section 1902(f) States

- a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1992: 100 percent

- b. Levels:

<u>Family Size</u>	<u>Income Level</u>
1	\$776
2	1,041

TN No. 04-05

Approved: 3/25/04

Effective Date: 4/1/04

Supersedes TN No. 03-07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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INCOME ELIGIBILITY LEVELS (continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1987

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff.	Jan. 1, 1989:	π 80 percent	π _____ percent (no more than 100)
Eff.	Jan. 1, 1990:	π 85 percent	π _____ percent (no more than 100)
Eff.	Jan. 1, 1991:	π 95 percent	π _____ percent (no more than 100)
Eff.	Jan. 1, 1992:	100 percent	

b. Levels:

<u>Family Size</u>	<u>Income Levels</u>
1	\$
2	\$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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INCOME LEVELS (continued)

D. MEDICALLY NEEDY

Applicable to all groups.

Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for <u>1</u> months	Amount by which Column (2) exceeds limits specified in 1/ 42 CFR 435.1007	Net income level for persons living in rural areas for months	Amount by which Column (4) exceeds limits specified in 1/ 42 CFR 435.1007
<input type="checkbox"/> Urban only				
<input type="checkbox"/> Urban & rural				
1	\$	\$	\$	\$
2	\$	\$	\$	\$
3	\$	\$	\$	\$
4	\$	\$	\$	\$
For each additional person, add:	\$	\$	\$	\$

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN No. 03-04 Approval Date 03/11/03 Effective Date 02/01/03
 Supersedes TN No. 02-14

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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SUPPLEMENT 1 TO ATTACHMENT 2.6-A
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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INCOME LEVELS (continued)

D. MEDICALLY NEEDY

X Applicable to all groups. Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for <u>1</u> months	Amount by which Column (2) exceeds limits specified in 1/ 42 CFR 435.1007	Net income level for persons living in rural areas for months	Amount by which Column (4) exceeds limits specified in 1/ 42 CFR 435.1007
<input type="checkbox"/> Urban only				
<input checked="" type="checkbox"/> Urban & rural				
5	\$ 879	\$	\$	\$
6	\$1,006	\$	\$	\$
7	\$1,119	\$	\$	\$
8	\$1,233	\$	\$	\$
9	\$1,313	\$	\$	\$
10	\$1,452	\$	\$	\$
For each additional person, add:	\$139	\$	\$	\$

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN No. 91-17
Supersedes
TN No.

Approval Date 10/4/91

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HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Page replaced by 13-0012 in section 8

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A</u>
<u>2</u>	<u>N/A</u>

b. Optional Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A</u>
<u>2</u>	<u>N/A</u>

TN No. 98-03

Approval Date 5/18/98

Effective Date 3/1/98

Supersedes TN No. 91-25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) Condition or Requirement

Page replaced by 13-0012 in section 8

2. Infants

a. Mandatory Group of Infants

 Same as resource levels in the State's approved AFDC plan.

 X Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u> 1 </u>	<u> N/A </u>
<u> 2 </u>	<u> N/A </u>
<u> 3 </u>	<u> N/A </u>
<u> 4 </u>	<u> N/A </u>
<u> 5 </u>	<u> N/A </u>
<u> 6 </u>	<u> N/A </u>
<u> 7 </u>	<u> N/A </u>
<u> 8 </u>	<u> N/A </u>
<u> 9 </u>	<u> N/A </u>
<u> 10 </u>	<u> N/A </u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) Condition or Requirement

Page replaced by 13-0012 in section 8

b. Optional Group of Infants

 Same as resource levels in the State's approved AFDC plan.

 X Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u> 1 </u>	<u> N/A </u>
<u> 2 </u>	<u> N/A </u>
<u> 3 </u>	<u> N/A </u>
<u> 4 </u>	<u> N/A </u>
<u> 5 </u>	<u> N/A </u>
<u> 6 </u>	<u> N/A </u>
<u> 7 </u>	<u> N/A </u>
<u> 8 </u>	<u> N/A </u>
<u> 9 </u>	<u> N/A </u>
<u> 10 </u>	<u> N/A </u>

TN No. 98-03 Approval Date 5/18/98

Effective Date 3/1/98

Supersedes TN No. 91-25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Page replaced by 13-0012 in section 8

3. Children

- a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (children who have attained age 1 but have not attained age 6.)

Same as resource levels in the State's approved AFDC plan.

- X Less restrictive than the AFDC levels and are as follows:

Family Size Resource Level

1 N/A

2 N/A

3 N/A

4 N/A

5 N/A

6 N/A

7 N/A

8 N/A

9 N/A

10 N/A

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b. Mandatory Group of Children under section 1902(a)(10)(i)(VII) of the Act.
(Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

 Same as resource levels in the State's approved AFDC plan.

 X Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
<u> 1 </u>	<u> N/A </u>
<u> 2 </u>	<u> N/A </u>
<u> 3 </u>	<u> N/A </u>
<u> 4 </u>	<u> N/A </u>
<u> 5 </u>	<u> N/A </u>
<u> 6 </u>	<u> N/A </u>
<u> 7 </u>	<u> N/A </u>
<u> 8 </u>	<u> N/A </u>
<u> 9 </u>	<u> N/A </u>
<u> 10 </u>	<u> N/A </u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Page replaced by 13-0012 in section 8

- b. Optional Group of Children under Section 1902(1)(1)D of the Act.
- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
1	N/A
2	N/A
3	N/A
4	N/A
5	N/A
6	N/A
7	N/A
8	N/A
9	N/A
10	N/A

TN No. 98-07

Supersedes

TN No.

Approval Date 10/22/98

Effective Date 7/1/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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4. Aged and Disabled Individuals

 Same as SSI resource levels.

 More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
--------------------	-----------------------

 1

 2

 3

 4

 5

 Same as medically needy resource levels (applicable only if State has a medically needy program)

TN No. 91-25

Supersedes

Approval Date 1/23/92

Effective Date 11/1/91

TN No.

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

___ Except those specified below under the provisions of section 1902(f) of the Act.

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	
<u>2</u>	
<u>3</u>	
<u>4</u>	
<u>5</u>	
<u>6</u>	
<u>7</u>	
<u>8</u>	
<u>9</u>	
<u>10</u>	

For each additional person

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

SUPPLEMENT 3 TO ATTACHMENT 2.6-A
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OMB NO: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Income deductions will be applied for the post-eligibility treatment of income of individuals receiving necessary medical and remedial care, not covered under the State Plan but recognized under state law.

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #91-25
SUPPLEMENT 4 TO ATTACHMENT 2.6-A
Page 1

OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to state supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

TN No. 91-25

Supersedes

TN No. _____

Approval Date 1/23/92

Effective Date 11/1/91

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD) Transmittal #91-25
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OMB NO.: 0938-

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

N/A

TN No. 91-25
Supersedes
TN No. 87-21

Approval Date 1/23/92

Effective Date 11/1/91
HCFA ID: 7985E

Transmittal #91-25

Revision: HCFA-PM-91- 4 (BPD)SUPPLEMENT 5a TO ATTACHMENT 2.6-A
AUGUST 1991 Page 1

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

N/A

TN No. 91-25
Supersedes
TN No. 87-21

Approval Date 1/23/92

Effective Date 11/1/91
HCFA ID: 7985E

Transmittal #85-3
 Revision: HCFA-AT-85-3 SUPPLEMENT 6 TO ATTACHMENT 2.6-A
 FEBRUARY 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level			Income Disregards
	Federal	State	<u>Gross</u>	<u>Net</u>	Couple	Employed
			1 person	1 person		
(1)	(2)	(3)	(4)	(5)		
1. Persons living outside a medical facility - may be living independently or in community-based care.		X	*	**		\$65
2. Persons living in a medical facility.		X	*	**		\$65

*300% of the current SSI standard payment amount for one person in a household of one.
 **300% of the current SSI standard payment amount for a couple.

TN No. <u>85-3</u>	Approval Date <u>8/9/85</u>	Effective Date <u>4/1/85</u>
Supersedes TN No. <u>81-34</u>		

Revision: HCFA-PM-91-4 (BDP) Transmittal #91-25
AUGUST 1991 Page 1 SUPPLEMENT 7 TO ATTACHMENT 2.6-A
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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INCOME LEVELS FOR 1902(F) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

N/A

TN No. 91-25
Supersedes
TN No. 85-3

Approval Date 1/23/92

Effective Date 11/1/91
HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BDP) Transmittal #91-25
AUGUST 1991 Page 1 SUPPLEMENT 8 TO ATTACHMENT 2.6-A
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation(s)	Condition or Requirement
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RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

N/A

TN No. 91-25

Supersedes

TN No. 85-3

Approval Date 1/23/92

Effective Date 11/1/91

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

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MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

The following income regulations apply to Working Disabled individuals as defined in Section 1902(a)(10)(A)(ii)(XIII) of the Social Security Act.

- (a) The total amount of payments for Employment and Independence Expenses (EIEs) shall be excluded from income when determining eligibility.

The excluded expense shall be utilized after all other SSI income disregards have been exhausted.

Employment and Independence Expenses shall include any expense that will be determined by the state to enhance an individual's independence and increase employment opportunities.

- (b) The total amount of payments made to Approved Accounts, described in Supplement 8b, shall be excluded when determining eligibility.

The excluded expense shall be utilized after all other SSI income disregards have been exhausted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

1. The following income disregards apply to; Qualified Medicare beneficiaries under Section 1902(a)(10)(E)(i), SLMB under Section 1902(a)(10)(E)(iii), QI1 under Section 1902(a)(10)(E)(iv), working disabled under section 1902(a)(10)(A)(ii)(XIII), and optional categorical under Section 1902(a)(10)(A)(ii)(I).

(a) wages paid by the Census Bureau for temporary employment related to Census activities are disregarded.

13-0012 replaced #2 of this page

2. **The state disregards the difference between the current TANF income standard (as approved in the State's title IV-A State plan) and the AFDC income standard in effect on July 16, 1996 (as specified in Supplement 1 to Attachment 2.6A page 1). This disregard applies to the following eligibility groups: Section 1902 (a)(10)(A)(i)(III), 1902(a)(10)(A)(ii)(I), 1902(a)(10)(A)(ii)(IV), 1902(a)(10)(A)(ii)(VIII)**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

3. The state disregards all income for Children with Non IV-E Adoption Assistance described in 1902(a)(10)(A)(ii)(VIII) of the Act addressed in Attachment 2.2-A, page 14.
4. The state disregards all income for all reasonable classification of children covered by the state under 42 CFR 435.222 as specified on Attachment 2.2-A pages 12, 13, and 13a and Supplement 1 to Attachment 2.2-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation(s)	Condition or Requirement
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MORE LIBERAL METHODS OF TREATING UNEARNED INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

1. The following unearned income regulations apply to Working Disabled individuals as defined in Section 1902(a)(10)(A)(ii)(XIII) of the Social Security Act.
 - (a) An unearned income shall be disregarded when determining eligibility under this section.
 - (b) The total amount of any special needs allowance shall also be disregarded. Special needs allowances are defined under Oregon Administrative Rules.

2. The following unearned income disregard applies to; Qualified Medicare beneficiaries under Section 1902(a)(10)(E)(i), SLMB under Section 1902(a)(10)(E)(iii), Q11 under Section 1902(a)(10)(E)(iv), qualified disabled and working individuals covered under Section 1902(a)(10)(E)(ii), working disabled under section 1902(a)(10)(A)(ii)(XIII), and aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under Section 1902(a)(10)(A)(ii)(X) of the Act.
 - (a) Unearned shelter-in-kind income is disregarded.

TN No. 17-0001 Approval Date 3/10/17 Effective Date 4/1/17
Supersedes TN No. 98-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

The following resource income regulations apply to Working Disabled individuals as defined in Section 1902(a)(10)(A)(ii)(XIII) of the Social Security Act.

- (a) A total of up to \$5,000 of available resources shall be disregarded.
- (b) A resource disregard shall be given to a Working Disabled individual who holds monies in any Approved Accounts.

The resource disregard shall equal the total of all monies held in such accounts.

These accounts will be held separate from non-exempt resources.

Approved Accounts shall be used to save for any expense that will be determined by the state to enhance an individual's independence and increase employment opportunities. Also included as an Approved Account shall be any account commonly used for future retirement and medical needs, including but not limited to IRAs, KEOGS and Medical Savings Accounts (MSAs).

Approval for such accounts shall be obtained by the individual prior to the utilization of such disregard.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

1. The following resource disregards apply to those eligible individuals as defined in Section 1902(a)(10)(A)(ii)(V) of the Social Security Act.
 - (a) The state disregards the total value of household goods and personal effects.
 - (b) Non exempt real property which is up for sale is excluded as long as owners verify they are making reasonable efforts to sell it.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

For annuities meeting the criteria contained in Supplement 8 to Attachment 2.6A, page 4, Item C, the amount of funds in the annuity account are disregarded as countable resources in determining eligibility for individuals under 42 CFR 435.217, 42 CFR 435.236 and Section 1902(a)(10)(E) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
C.	Effective October 1, 2005 the following shall govern annuities. An annuity purchased on or after October 1, 2005 by or for an individual using the individual's assets will be considered an available resource unless it meets all of the following criteria: <ol style="list-style-type: none">1. The annuity is irrevocable;2. The annuity pays principle and interest out in equal monthly installments over the actuarial life expectancy of the annuitant;3. If an unmarried client is the annuitant, the annuity must specify that upon the death of the client the first remainder beneficiary is either (a) or (b) below:<ol style="list-style-type: none">(a) The Department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client, or(b) The client's child who meets the SSI disability criteria based on blindness or disability in the event that the child survives the client, AND the Department in the event that the child does not survive the client, up to the amount of medical benefits provided on behalf of the client;4. If the community spouse is the annuitant, the annuity must specify that upon the death of the community spouse the first remainder beneficiary is either (a) or (b) below:<ol style="list-style-type: none">(a) The client, in the event that the client survives the community spouse AND the Department, in the event that the client does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client or(b) The community spouse's child who meets the SSI disability criteria based on blindness or disability in the event that the child survives the community spouse, AND the client in the event that the child does not survive the community spouse; and5. The annuity is issued by a business licensed and approved by the state in which the annuity is purchased, to issue commercial annuities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State Non-Section 1902(f) State

The following resource methodology applies to Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act.

All resources shall be excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) The following more liberal methodology applies to individuals who are
1917(b)(1)(C) eligible for medical assistance under one of the following eligibility groups:

Section 1902(a)(10)(A)(ii)(V) of the Social Security Act

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a “qualified state long-term care insurance partnership” policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

- X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State’s Insurance Department.
- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
 - The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
 - The policy was issued no earlier than the effective date of this State plan amendment.

TN #07-07
Supersedes TN #

Approval Date 10/18/07 Effective Date 1/1/08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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TRANSFER OF RESOURCES

1902(f) and 1917
of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

- A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).
 - 1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.
 - a. The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
b. []	The period of ineligibility is less than 24 months, as specified below:
c. [X]	The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.
*d. [X]	The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceed \$24,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows: The period of ineligibility continues for as many full months as equals the uncompensated value divided by \$1,000. *Based on Lewis vs. Hegstrom, 1984.
e. [X]	For resources transferred on or after July 1, 1988 the period of ineligibility is the lesser of thirty months or the total number of months divided by \$1,970, unless the resources were transferred to the individual spouse or blind or disabled child.

TN No. 90-20
Supersedes
TN No. _

Approval Date 10/12/90

Effective Date 7/1/90

Revision: HCFA-AT-85-3 (BERC)
FEBRUARY 1985

Transmittal #90-20
SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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2. Transfer of the home of an individual who is an inpatient in a medical institution.

X A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. For resources transferred prior to July 1, 1988. Subject to the exceptions on page 5 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

*The period of ineligibility begins with the month of disposal of the home and continues for as many full months as equals the uncompensated value divided by \$1,350.00.

* Based on Lewis vs. Hegstrom, 1984.

TN No. _
Supersedes
TN No. _

Approval Date 10/12/90

Effective Date 7/1/90
HCFA ID: A093E/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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- For resources transferred prior to July 1, 19
- b. X Subject to the exceptions on page 5 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 2A months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

* The period of ineligibility Continues for as many full months as equals the uncompensated value divided by \$1,350.00.

- c. X Subject to the exemptions on page 5 of this supplement, if the home was transferred on or after July 1, 1988, the period of ineligibility is the lesser of thirty months or the total number of months divided by \$1,970.

* Based on Lewis vs. Hegstrom, 1984.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	<p>No individual is ineligible by reason of item A.2 if--</p> <ul style="list-style-type: none"> <li data-bbox="665 619 1459 787">i. A satisfactory showing, is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home; <li data-bbox="665 829 1459 1102">ii. Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act; <li data-bbox="665 1144 1459 1312">iii. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or <li data-bbox="665 1354 1459 1417">iv. The agency determines that denial of eligibility would work an undue hardship. <li data-bbox="665 1459 1459 1730">v. For transfers on or after July 1, 1988, the home was transferred to the individuals spouse, blind or disabled child, a child under age 21, a sibling who has equity in the home and was residing in the home at least one year, or a son or daughter who was residing in the home at least two years before the individual began a continuous period of care that permitted the individual to reside at home.

TN No. 90-20 Approval Date 10/12/90 Effective Date 7/1/90
Supersedes TN No.

Revision: HCFA-AT-85-3 (BERC)
FEBRUARY 1985

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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3. 1902(f) states

 Under the provisions of section 1902(f) of the Social security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less:

2. If the uncompensated value of the transfer is more than \$12,000:

TN No. 85-3
Supersedes
TN No.

Approval Date 8/9/85

Effective Date 4/1/85
HCFA ID: 4093E/0002P

Revision: HCFA-AT-85-3 (BPD)
FEBRUARY 1985

Transmittal #85-3
SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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3. If the agency sets a period of ineligibility of less than 24 months and applies to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

TN No. 85-3
Supersedes
TN No.

Approval Date 8/9/85

Effective Date 4/1/85

HCFA ID: 4093E/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	TRANSFER OF ASSETS
1917(c)	FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER February 8, 2006, the agency provides for the denial of certain Medicaid services. 1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date. The agency does not provide medical assistance coverage for institutionalized individuals for the following services: Nursing facility services; Nursing facility level of care provided in a medical institution; Home and community-based services under a 1915(c) or (d) waiver. 2. Non-institutionalized individuals: ____ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act: The agency withholds payment to non-institutionalized individuals for the following services: Home health services (section 1905(a)(7)); Home and community care for functionally disabled elderly adults (section 1905(a)(22)); Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24). ____ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	TRANSFER OF ASSETS
3.	<p><u>Penalty Date</u>--The beginning date of each penalty period imposed for an uncompensated transfer of assets is <u>the later of</u>:</p> <ul style="list-style-type: none">• the first day of a month during or after which assets have been transferred for less than fair market value; <p><u> </u> The State uses the first day of the month in which the assets were transferred</p> <p><u> X </u> The State uses the first day of the month after the month in which the assets were transferred</p> <p>or</p> <ul style="list-style-type: none">• the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid; <p>AND</p> <p>which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.</p>
4.	<p><u>Penalty Period - Institutionalized Individuals</u>--</p> <p>In determining the penalty for an institutionalized individual, the agency uses:</p> <p><u> X </u> the average monthly cost to a private patient of nursing facility services in the State at the time of application;</p> <p><u> </u> the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.</p>
5.	<p><u>Penalty Period - Non-institutionalized Individuals</u>--</p> <p>The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;</p> <p><u> </u> imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<u>TRANSFER OF ASSETS</u>	
6.	<p><u>Penalty period for amounts of transfer less than cost of nursing facility care--</u> <u>X</u> Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4. <u>X</u> The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.</p>
7.	<p><u>Penalty periods - transfer by a spouse that results in a penalty period for the individual--</u></p> <p>(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains. (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.</p>
8.	<p><u>Treatment of a transfer of income—</u></p> <p>When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value. When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment. <u>X</u> For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above. <u>X</u> For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.</p>
9.	<p><u>Imposition of a penalty would work an undue hardship--</u> The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	<p style="text-align: center;">TRANSFER OF ASSETS</p> <p>Application of a transfer of assets penalty would deprive the individual:</p> <ul style="list-style-type: none">(a) Of medical care such that the individual's health or life would be endangered; or(b) Of food, clothing, shelter, or other necessities of life such that the client's health or life would be endangered; and(c) has the client provided proof that there is no other means for meeting these needs by exploring and pursuing all reasonable means to recover the assets to the satisfaction of the Department, including legal remedies and consultation with an attorney, and cooperating with the Department to take action to recover the assets.
10.	<p><u>Procedures for Undue Hardship Waivers</u></p> <p>The agency has established a process under which hardship waivers may be requested that provides for:</p> <ul style="list-style-type: none">(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;(b) A timely process for determining whether an undue hardship waiver will be granted; and(c) A process, which is described in the notice, under which an adverse determination can be appealed. <p>These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.</p>
11.	<p><u>Bed Hold Waivers For Hardship Applicants</u></p> <p>The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:</p> <p style="padding-left: 40px;">____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed ____ days (may not be greater than 30).</p>

MARCH 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

The agency does not apply the trust provisions in any case in which the agency determined that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship.

The provisions of this rule may be waived if the agency determines denial of benefits would create an undue hardship on the client based on the following:

- (a) The local unit may determine hardship if:
 - (1) The absence of the services requested may result in a life-threatening situation.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is \$_____.

October 1991

Transmittal #92-3
SUPPLEMENT 11 TO ATTACHMENT 2.6-A
Page 1
OMB No.:

State/Territory: OREGON

Citation	Condition or Requirement
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COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES

1902(u)
of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

The methodology as described in SMM section 3598.

Another cost-effective methodology as described below.

TN No. 92-3
Supersedes
TN No. _____

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Effective Date 1/1/92
HCFA ID: 7985E

Revision: HCFA-PM-99-1

Transmittal #99-02
SUPPLEMENT 12 TO ATTACHMENT 2.6-A
Page 1
OMB No.:0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 5 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimates) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

TN No. 99-02
Supersedes
TN No. 98-05

Approval Date 7/1/99

Effective Date 4/1/99

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Page replaced by 13-0012 in section 8

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The state covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State Plan effective July 16, 1996:

X Pregnant women with no other children.

X AFDC children age 18 who are full-time students in a secondary school or the equivalent level of vocational or technical training.

 In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 with the following modifications.

 The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

 The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

1. Disregard either 50% or the \$90 and \$30 and 1/3 of all earned income as provided for in the AFDC State plan, whichever is greater.
2. For self employed clients, disregard either 50% of gross income or the cost of providing the income, whichever is greater.
3. Disregard all In-Kind, Shelter-In-Kind, and Jury Duty income.
4. Either include the needs and income of both parents, regardless of their marital status as long as they are living in the same household as a dependent or unborn child, or deem/disregard the unmarried parent's income as provided in the State plan, whichever results in eligibility for the parent/child.
 - 4a. Disregard wages paid by the Census Bureau for temporary employment related to Census activities.
 - 4b. disregard the difference between the current TANF income standard (as approved in the State's title IV-A State plan) and the AFDC income standard in effect on July 16, 1996 (as specified in Supplement 1 to Attachment 2.6A page 1).

Page replaced 13-0012 in section 8

5. For families with a needy caretaker relative who is not the parent of the dependent child, either include the needs and income of the spouse and dependent children of the caretaker relative or deem the spouses income as provided in the State plan, whichever results in eligibility for the dependent child.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

All In-Kind, Shelter-In-Kind, and Jury Duty income was counted.

- The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.
- X The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997:
1. Waiver to Title IV-A, Sec. 402(a)(7)(B) of the Social Security Act and 45 clients from \$1,000 to \$2,500 and to \$10,000 for JOBS participants who are progressing in their self-sufficiency plans.
 2. Waiver to Title IV-A, Sec. 402(a)(7)(B) of the Social Security Act and 45 CFR 233.20(a)(3)(i)(2). Raise the AFDC vehicle equity limit from \$1,500 to \$9,000.
 3. Waiver to Title IV-A, Sec. 407(a) of the Social security Act and 45 CFR 233.100(a)(1)(i). Elimination of the 100 hour rule as a determiner of unemployment to two-parent families. If the family meets the income standard, eligibility continues regardless of the number of hours the principle wage earner works.
 4. Waiver to title IV-A, Sec. 402(a)(17) of the Social Security Act and 45 CFR 233.20(a)(3)(i)(B). Treat lump sum payments as an asset rather than as income. The client does not become eligible for AFDC for the number of months equaling the sum of money divided by the monthly grant.

TN No. 97-08

Supersedes

TN No.

Revision: CMS-10283

Approval Date 11/10/98

Effective Date 10/1/97

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

ELIGIBILITY UNDER SECTION 1925 OF THE ACT TRANSITIONAL MEDICAL ASSISTANCE

The state covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to loss of a time-limited earned income disregard. (42 CFR 435.112, 1902(a)(52), 1902(e)(1), and 1925 of the Act)

The amount, duration, and scope of the services for this coverage are specified in Section 3.1 of this state plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under 1931 (months of retroactive eligibility may be used to meet this requirement):

During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The family must have been Medicaid eligible under section 1931 for 1 month preceding the month in which the family became ineligible under section 1931.

The State extends Medicaid eligibility under TMA for an initial period of:

6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.

12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

TN 09-09

Approval Date: 8-19-09

Effective Date: 10-1-09

Supercedes TN:

January 1992

Transmittal #07-11
SUPPLEMENT 13 TO ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

Section 1924 Provisions

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility, the State uses the minimum resource standard permissible under Section 1924 of the Social Security Act. P&I
- C. The definition of undue hardship for purposes of determining if the institutionalized spouses receive Medicaid in spite of having excess countable resources is listed below:

The person is in extreme need of medical care and the care would not be provided if the person was not eligible. There is convincing evidence that the excess resource cannot be made available to meet the person's immediate needs.

TN No. 07-11

Approved 1/23/08

Effective Date: 1/1/08

Supersedes TN No. 07-01

HCFA-PM-95-7 (MB)
10/95

Transmittal #95-12
SUPPLEMENT 14 TO ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB)
INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

NOT APPLICABLE - Oregon does not cover
this optional group.

TN No. 95-12
Supersedes
TN No.

Approval Date 11/21/95 Effective Date 10/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

\$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is _____.

This higher standard applies statewide.

This higher standard does not apply statewide. It only applies in the following areas of the State:

This higher standard applies to all eligibility groups.

This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

ASSET VERIFICATION SYSTEM

- 1940(a)
of the Act
1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
 - A. The request and response system must be electronic:
 - (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
 - (2) The system cannot be based on mailing paper-based requests.
 - (3) The system must have the capability to accept responses electronically.
 - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
 - C. The system must establish and maintain a database of FIs that participate in the agency's AVS.
 - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.
 - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

ASSET VERIFICATION SYSTEM

2. System Development

A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Oregon intends to join with Washington and other willing Western states to create a consortium of states intended to ensure that Medicaid Aged, Blind, and/or Disabled (ABD) asset information housed in financial institutions in cities within Oregon and bordering Oregon will be located for ABD recipient/applicant asset verification. The consortium will contract with an existing asset verification entity like HMS, Acuity, or some other entity that has existing contracts with Oregon border cities and states. Oregon is required to put forth a Request for Proposal process when contracting with vendors for services. The system and entity chosen will be able to comply with the following requirements:

1. An electronic process for asset verification
2. A database of financial institutions that provide data to the entity meeting the geographic requirements of the consortium
3. A 5-year look back of the assets on individual applicants, recipients, spouses and partners
4. A secure, system based on a recognized industry standard as defined by the U.S Commerce Department's National Institute
5. Verification requests will include both open and closed asset account information
6. The acceptable asset verification entity will provide adequate data for the generation of all required reports expected to meet federal reporting requirements such as the number of requests, number of responses and amounts of undisclosed assets found.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 2/26/14 (insert date). In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

TN No: 13-22
Supersedes TN No.

Approval Date: 7/21/14

Effective Date: 1/1/14

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
	For each population group, indicate the lower of: The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion Plan.	N	N	N	N
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion Plan.	N	N	N	N
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion Plan.	N	N	N	N

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
	For each population group, indicate the lower of: <ul style="list-style-type: none"> • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion Plan	NA	NA	NA	NA
Childless Adults	Attachment A, Column C, Line 51 of Part 2 of CMS approved MAGI conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion Plan	NA	NA	NA	NA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

- Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.
- Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B)

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

- Applies existing state data from periods before January 1, 2014.
- Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. An enrollment cap adjustment is applied (complete items 2 through 4).
 An enrollment cap adjustment is not applied (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that Oregon covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

 Yes. The combined enrollment cap adjustment is described in Attachment C
 No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:
 Applies special circumstances adjustment(s).
 Does not apply a special circumstances adjustment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

2. The state:

- Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
- Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

The state does not have any relevant populations requiring such transitions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

- Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 4)
- Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

TN No: 13-22
Supersedes TN No.

Approval Date: 7/21/14

Effective Date: 1/1/14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Part 5 - State Attestations

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- Attachment A – Conversion Plan Standards Referenced in Table 1
- Attachment B – Resource Criteria Proxy Methodology
- Attachment C – Enrollment Cap Methodology
- Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- Attachment E – Transition Methodologies

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Supersedes TN No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OREGON

FINANCIAL ELIGIBILITY CONDITIONS AND REQUIREMENTS

I. GENERAL-APPLICABLE TO THE CATEGORICALLY NEEDY

A. Financial responsibility is imposed on the following relatives with respect to care and services provided under the plan:

1. Spouse for spouse

Yes.

Yes, with the following exceptions:

No responsibility is imposed

2. Parents for children under age 21

Yes.

Yes, with the following exceptions:
Limited to children under age 18

No responsibility is imposed

3. Parents for children of any age who are blind

Yes.

Yes, with the following exceptions:

No responsibility is imposed

TN No. 03-04

Approval Date 03/11/03

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Supersedes TN No. 02-14

4. Parents for children of any age who are disabled

Yes.

Yes, with the following exceptions:

No responsibility is imposed

B. Only those resources which the relative actually makes available to the applicant shall be used in determining the amount of Title XIX Medical Assistance.

Not applicable. No relatives are held financially responsible for costs of medical and remedial care and services.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Transmittal #91-25
ATTACHMENT 3.1-A
Page 1
OMB No.: 0938-

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO
THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
Provided: / / No limitations /X/ With limitations*
- 2.a. Outpatient hospital services.
Provided: / / No limitations /X/ With limitations*
- b. Rural health clinic services and other ambulatory service furnished by a rural health clinic (which are otherwise included in the state plan).
/X/ Provided / / No limitations /X/ With limitations*
/ / Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
Provided: / / No limitations /X/ With limitations*
- ~~d. Ambulatory services offered by a health center receiving funds under section 329, 330 or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
/X/ Provided / / No limitations /X/ With limitations*~~
3. Other laboratory and x-ray services.
Provided: / / No limitations /X/ With limitations*

*Description provided on Attachment.

TN No. 91-25

Supersedes

TN No. 90-32

Approval Date 1/23/92 Effective Date 11/1/91

HCFA ID: 7986E

LIMITATIONS ON SERVICES

I. Inpatient Hospital Services

Selected non-emergency surgical and medical services provided in an inpatient setting require pre-admission screening for medical necessity. Such screening shall be accomplished by a professional medical review organization, or by OMAP. A notice of prior authorization of payment must be issued. Non-emergency inpatient services, excluding maternity and newborn admissions, provided to enrollees in a Managed Care Organization require authorization by the Plan. Transfers or admissions for the purpose of providing rehabilitative services must be prior authorized by the professional medical review organization or by a contracted Managed Care Organization. A notice of prior authorization of payment must be issued - The professional medical review organization may require a second opinion before granting prior authorization.

Services identified by the Division as not covered or services deemed not to be medically necessary are not reimbursed by the Division.

2.a Outpatient Hospital Services

Outpatient services do not require prior authorization with the exception of services identified below:

- a. Non-emergency outpatient services provided to clients enrolled in a Physician Care Organization or Health Maintenance Organization require prior authorization from the PCO or HMO.
- b. Most physical therapy, occupational therapy, speech-language therapy, audiological services, prosthetic and orthotic supplies, oxygen, specific vision services, specific drugs, durable medical equipment, selected surgical procedures, and non-emergency dental services require prior authorization when delivered in an outpatient setting.

Reimbursement for outpatient non-emergency hospital services in non-contiguous out-of-state hospitals must be prior authorized. Non-contiguous out-of-state hospitals are defined as those hospitals located more than 75 miles from Oregon. Emergency services are those determined by a licensed health care professional to be essential to prevent death, relieve service pain, and/or treat acute illness or injury.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS OF SERVICES (Continued)

b. Rural Health Clinic Services

Rural Health Clinic Services (RHC) services are defined in subparagraphs (B) and (C) of section 1905(a)(2). Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. These services include but are not limited to services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and nurses.

c. Federally Qualified Health Center (FQHC) Services

FQHC services are defined in subparagraphs (B) and (C) of section 1905(a)(2). Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. These services include but are not limited to services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and nurses.

3. Clinical laboratory and pathology services and procedures*

*performed by any provider are reimbursable only after the provider is certified by HCFA as meeting the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and HCFA has notified OMAP of the assignment of a ten-digit CLIA number. Enforcement of compliance with CLIA requirements will occur only after notification in writing from HCFA.

*are provided subject to the rules and procedures set forth in the Medical-Surgical Services Administrative Rules and Billing Instructions for Oregon Medical Assistance Programs.

Revision: HCFA-PM-92-3 (MB)
APRIL 1992

Transmittal #13-08
ATTACHMENT 3.1-A
Page 2

State/Territory: Oregon

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Provided: No limitations With limitations*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- 4.c. Family planning services and supplies for individuals of childbearing age.
- Provided: No limitations With limitations*
- 4.d. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women.
- Provided: No limitations With limitations*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
- Provided: _ No limitations With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
- Provided: _ No limitations With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.
- Provided: No limitations With limitations*

* Description provided on Attachment.

TN No. 13-08
Supercedes TN No. 92-16

Approval Date 8/14/13

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS ON SERVICES (Cont)

4.a. Nursing Facility Services for age 21 or Over

Nursing facility service is subject to a maximum cost reimbursement.

4.b. Early and Periodic Screening, Diagnosis and Treatment of those Under Age 21

Dental screening, diagnosis and treatment begin in accordance with the American Academy of Pediatric Dentistry's Dental Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents.

Coverage of transplants and transplant-related services is available for individuals under the age of 21 as described in Attachment 3.1-E.

All medically necessary diagnosis and treatment services permitted under Medicaid statute will be furnished to EPSDT recipients. Services not currently in the state plan, but that are available to EPSDT recipients are hospice, case management, and respiratory care services, if medically necessary. The service limitations delineated in Attachment 3.1-A do not apply to EPSDT recipients if the service is determined to be medically necessary by the Medical Assistance Programs medical or dental consultants.

4.c. Family Planning Services

Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size. Clients may seek family planning services from any provider enrolled with the Division, even if the client is enrolled in a Managed Care entity. Family Planning services include: Annual exams; Contraceptive education and counseling to address reproductive health issues; Laboratory tests; Radiology services; Medical and surgical procedures, including tubal ligations and vasectomies; Pharmaceutical supplies and devices.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.d. Tobacco Cessation Counseling Services for Pregnant Women:

1) Face-to-Face Tobacco Cessation Counseling Services provided

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under state law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under state law and who is specifically designated by the Secretary in regulation (none are designated at this time)

❖ Describe any limits on who can provide these counseling services.

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations: There are no limitations for tobacco cessation counseling. PW are allowed up to 4 quit attempts per 12 month period and as many as 10 FTF counseling sessions per quite attempt.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. a. and b. Physicians Services, Medical and Surgical Services provided by dentist

Physician services are covered for the diagnosis of conditions, preventative care services including immunizations, acute care and treatment of chronic health conditions. Payment for physicians and oral surgeon services is subject to Health Evidence Review Commission, Prioritized List of Health Services as authorized under the 1115 waiver. The Health Services Commission's Prioritized List of Health Services is found on the Division website at: <http://www.oregon.gov/oha/healthplan/Pages/priorlist.aspx>.

Prior Authorization:

Service categories that require a prior authorization include elective rehabilitative procedures; transplants; MRI; bariatric surgeries and evaluations; laparoscopy; selective reconstructive surgeries such as eye lid correction. Exceptions for non-covered services or services with limitations are allowed when medically necessary and prior authorized by the Division. The Division may disallow payment for physicians' or oral surgeon services provided during inpatient hospitalizations in which prior approval was required but not obtained. Reimbursement for non-emergency services provided by out-of-state physicians or oral surgeons, other than in contiguous areas, must be prior authorized.

The Division's Administrative rules are used in conjunction with the Prioritized List of Health Services to outline additional criteria such as prior authorization criteria, billing and payment information. Payment of services to foster children and children in subsidized adoption who are placed by the Children's Services Division anywhere in the United States is on the same basis as services provided in Oregon.

For the purposes of Oregon Medicaid and specifically the Medicaid EHR Incentive Program, services performed by Optometric physicians, subject to 42 CFR 441.30, are included in the term "physician" services under this state plan and are reimbursed the same under the Physician fee schedule.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. a. and b. Physicians Services, Medical and Surgical Services provided by dentist (Cont)

Optometric physicians are subject to Oregon scope of practice laws and are held to the same standards as are persons licensed as physicians to practice medicine and surgery by the Oregon Medical Board.

Optometric physicians are eligible providers for the EHR incentive program to the extent they provide services to children under 21 and meet any other criteria required for EHR.

6. a. Podiatrist Services

Selected procedures require prior authorization of payment. Routine foot care is excluded from coverage.

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LIMITATIONS ON SERVICES (Cont.)

6.b. Optometrist Services

Coverage includes all vision services for children and pregnant women (including routine vision exams, fittings, repairs, therapies and materials) provided by ophthalmologists, optometrists and opticians.

DMAP will not provide routine vision services and material to non-pregnant adults age 21 and older, except for clients with specific medical diagnoses.

Services that require prior authorization include contact lens, except for the medical condition of Keratoconus, vision therapy for adults or unclassified CPT procedures.

6.c. Chiropractor Services

Chiropractic services are in accordance with 42 CFR 440.60. Coverage is limited to rheumatoid arthritis and other inflammatory polyarthropathies, neurological dysfunction in posture and movement caused by chronic conditions, disorders of the spine with neurologic impairment, peripheral nerve entrapment, osteoarthritis and allied disorders, brachial plexus lesions and migraine headaches.

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b. Optometrists' services.

/X/ Provided: / / No limitations /X/ With limitations*
// Not provided.

c. Chiropractors' services.

/X/ Provided: / / No limitations /X/ With limitations
// Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations,
if any.
// Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations /X/ With limitations*

*Description provided on Attachment.

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- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

8. Private duty nursing services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on Attachment.

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6. d. **Other Practitioner Services**

In accordance with 42 CFR 440.60, the following licensed practitioners can provide Health care services in this state plan that are within their scope of practice as defined in Oregon Revised Statutes, Oregon Administrative Rules (OAR), and the applicable Boards or certifying agency's governing them. While some of the following practitioners must meet board certification requirements, all covered practitioners must meet state licensure requirements to be covered for services under this section:

Licensed practitioners:

1. Acupuncturists licensed by the Oregon Medical Board;
2. Behavior Analyst (BCBA) and Assistant Behavior Analyst (BCaBA) licensed by the Oregon Behavior Analyst Regulatory Board;
3. Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;
4. Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers who maintain certification as a Gambling Addiction Counselor, Certified by the Mental Health & Addiction Board of Oregon;
5. Counselors licensed by the Oregon Board of Licensed Professional Counselors and Therapist;
6. Counselors licensed by the Oregon Board of Licensed Professional Counselors and Therapist who maintain certification as a Gambling Addiction Counselor, Certified by the Mental Health & Addiction Board of Oregon;
7. Dental hygienists with an Expanded Practice Dental Hygienist Permit (EPDHP) licensed by the Oregon Board of Dentistry;
8. Dental Therapist licensed by the Oregon Board of Dentistry;
9. Denturists licensed by the Oregon Health Licensing Office;
10. Dietitian, (RDN) and (RD) licensed by the Oregon board of Licensed Dietitians;
11. Direct Entry Midwife licensed by the Oregon Board of Direct Entry Midwifery;
12. Electrologist, licensed by the Oregon State Board of Electrologists and Body Art Practitioners;

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6. d. **Other Practitioner Services**

Licensed practitioners (Cont):

13. Emergency Medical Technician (EMT), Advanced EMT (AEMT), EMT-Intermediate (EMT-I), Emergency Medical Responders (EMR), and Paramedics Licensed by the Oregon Health Authority;
14. Genetic Counselors licensed by the Oregon State Health Licensing Office;
15. Naturopathic physicians licensed by the Oregon Board of Naturopathic Medicine;
16. Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing;
17. Nurse Practitioner (NP) licensed by the Oregon Board of Nursing;
18. Pharmacists licensed by the Oregon Board of Pharmacy;
19. Physician Assistant (PA) licensed by the Oregon Medical Board;
20. Psychologist, (PhD & PsyD licensed by the Oregon Board of Psychology;
21. Psychologist, (PhD & PsyD licensed by the Oregon Board of Psychology who maintain certification as a Gambling Addiction Counselor, Certified by the Mental Health & Addiction Board of Oregon

Registered or Certified Non-licensed practitioners:

1. Certified Indian Health Service Community Health Aide Program providers, supervised by a Licensed Health Care Professional.
2. Gambling Addiction Counselor, certified by the Mental Health & Addiction Board of Oregon who are not otherwise a licensed practitioner. Must be supervised by a Licensed Health Care Professional.
3. Behavioral Analyst Interventionists:
Must be supervised by a Behavior Analyst (BCBA), an Assistant Behavior Analyst (BCaBA) or a Licensed Health Care Professional.

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6. d. **Other Practitioner Services (Cont)**

Registered or Certified non-licensed practitioners (Cont):

4. Non-traditional health workers (referred to a traditional health worker in OAR):
Must be supervised by existing licensed practitioners and perform services for them within the licensed practitioner's scope of practice. Licensed health providers are responsible for the work that they order, delegate or supervise when health care professionals work under their supervision. The state assures that any non-licensed service providers authorized by this section of Oregon's state plan will be supervised by a Licensed Health Care Professional.

For purposes of this State Plan a Licensed Health Care Professional (LHCP) includes Physicians*, Nurse Practitioners, Physician Assistants, Dentists, Dental hygienists with an Expanded Practice Permit, Ph.D. Psychologists, PsyD Psychologists, LCSW Social Workers and Licensed Professional Counselors. *covered in the state plan under physician services.

- a) Community Health Worker services are provided under the supervision of LHCP;
- b) Peer services are provided under the supervision of LHCP;
 - a. Personal Health Navigators services are provided under the supervision of LHCP;
 - b. Peer Wellness Specialist services are provided under the supervisions of a LHCP;
 - c. Peer Support Specialist services are provided under the supervision of a LHCP.

The state assures that only the Licensed Health Care Professional will bill for services.

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LIMITATIONS ON SERVICES (Cont.)

7. a. Home Health Services

Coverage and provider qualifications are in accordance with 42 CFR 440.70. Home health services are provided to eligible clients according to a written plan of treatment, in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services must be ordered by a physician, nurse practitioner, clinical nurse specialist or physician assistant, working within their scope of practice and State licensing regulations. The signed order must be on file at the Home Health Agency. The plan of care must be reviewed and signed by the ordering practitioner every 60 days to continue services.

For the initiation of home health services, a face-to-face encounter related to the primary reason the client requires home health services must occur not more than ninety (90) days before or thirty (30) days after the start of services. The face-to-face encounter must be conducted by a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife or physician assistant.

Prior authorization is required for home health services. Home Health services are provided by a registered nurse when no home health agency is available. Services are provided by home health agencies that meet conditions for participation in Medicare. Services are not covered if not medically appropriate, Medical Social Worker services, Registered Dietician counseling. Services requiring prior authorization are: Skilled nursing services and all therapy services. Some services are limited; skilled nursing visits are limited to two visits per day; therapy services are limited to one visit or evaluation per day. The limits for skilled nursing visits and therapy services can be exceeded by prior authorization and medical necessity.

7. b. Services of Home Health Aide

Services of a home health aide, employed by a Home Health Agency, giving personal care are provided according to a plan of treatment. All requirements listed for Home Health Services above apply to Home Health Aide services.

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LIMITATIONS ON SERVICES (Cont.)

7. c. Medical Supplies, Equipment, and Appliances

Coverage and provider qualifications are in accordance with 42 CFR 440.70. Medical supplies, equipment and appliances must be medically appropriate and suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Medical supplies, equipment and appliances may be ordered by a treating physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant working within their scope of practice and State licensing regulations. For the initial ordering of certain medical equipment, a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant must conduct a face-to-face encounter that is related to the primary reason the client requires medical equipment no more than 6 months prior to the start of services.

Medical supplies, equipment or appliance must be approved for marketing and registered or listed as a medical device by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended. Medical supplies are health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury. Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

Medicaid coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

A request for an individual medical appropriateness review may be made for any medical equipment, related supplies or services that are not identified as covered by the Division. If the request is denied, the client will be informed of their right to a fair hearing.

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LIMITATIONS ON SERVICES (Cont.)

7d. Physical, Occupational, Speech Therapy in Patient's Home

Coverage and provider qualifications are in accordance with 42 CFR 440.110. Physical, Occupational, Speech Therapy services in a Patient's Home must be prescribed by a physician with the signed order on file at the Home Health Agency. The plan of care must specify the type of services to be provided to the client, with respect to the professional who will provide them, the nature of the individual services, specific frequency and specific duration. The orders must indicate how many times per day, each week and/or each month the services are to be provided. The plan of care must be reviewed and signed by the physician every two months to continue services. Prior authorization is required for home health services. Services are provided by home health agencies that meet conditions for participation in Medicare. Services are not covered if they are not medically appropriate. Therapy services require Prior authorization and are limited to one visit or evaluation per day per. The limits are not a combined limit but applies to each individual therapy service type. Additional services can be authorized due to medical necessity.

8. Private Duty Nursing Services

The purpose of the Private Duty Nursing (PDN) Program is to reduce the cost of healthcare services through equally effective, more conservative, and/or less costly treatment. Eligible children must need continuous skilled nursing care that can be provided safely outside an institution; and have prior authorization from the agency (OHA or DHS). The provision of nursing services identified in conjunction with a child's IEP or IFSP will be provided pursuant to the Individuals with Disabilities Education Act (IDEA).

PDN services are provided in accordance with 42 CFR 440.80. PDN services meet complex medical needs for persons aged under 21 years who require skilled nursing care on a day-to-day basis. Services provide alternatives to institutionalization in a hospital or nursing facility and are not intended to supplant or replace other means of providing the services. Adults are not eligible.

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LIMITATIONS ON SERVICES (Cont.)

8. Private Duty Nursing Services (Cont)

PDN services are available through three programs:

- For children with anticipated need of 60 days or less, through the PDN program;
- For children with anticipated long term needs greater than 60 days, through the Medically Fragile Children's Program; and
- For children who need PDN or the same or similar services during school hours, through the school-based health services program.

Private duty nursing services must be prior authorized and meet the level of service criteria that measure specific nursing interventions needed. Nursing services must be medically appropriate and based on a physician's order which include: Nursing assessment; Nursing care plan; Documentation of condition and medical appropriateness; Identified skilled nursing needs; Goals and objectives of care provided. The nursing care plan and documentation supporting the medical appropriateness for private duty nursing must be reviewed to continue the service.

Private duty nursing is not covered:

- if the client is: a resident of a nursing facility; a resident of a licensed intermediate care facility for people with developmental disabilities; in a hospital; in a licensed residential care facility.
- solely to allow the client's family or caregiver to work or go to school;
- solely to allow respite for caregivers or client's family;

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9. Clinic services.
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.
10. Dental services.
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.
11. Physical therapy and related services.
- a. Physical therapy.
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.
- b. Occupational therapy.
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.
- c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

*Description provided on Attachment.

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9. Clinic Services

Payment for clinic services is in accordance with 42 CFR 440.90.

Free standing kidney centers

A center devoted specially to treat End Stage Renal Disease (ESRD).

Description of service:

Continuous Ambulatory Peritoneal dialysis, Continuous Cycling Peritoneal Dialysis, hemodialysis or ESRD.

Program coverage:

Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. The Division follows Medicare's criteria for coverage of Epoetin, Intradialytic Parenteral Nutrition services, and the frequency schedule for laboratory tests for ESRD services. When laboratory tests are performed at a frequency greater than specified by Medicare, the additional tests must medically justified by accompanying documentation.

Reimbursement:

This service is reimbursed according to attachment 4.19-B.

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9. Clinic Services (cont)

Freestanding ambulatory surgery centers

A distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and the expected duration of services would not exceed 24 hours following an admission. Ambulatory surgical center services must be provided in an "Ambulatory Surgical Center" or "ASC" as defined by 42 CFR 416 and other applicable federal and state laws, rules, and regulations.

Program coverage:

ASC services are limited to those services furnished in connection with or directly related to a covered surgical procedure approved by the Division. If the client has Medicare in addition to Medicaid and Medicare covers a surgery, but not in an ASC setting, then the surgery may not be performed in an ASC.

Prior authorization:

Services as referenced under Attachment 3.1-A, page 2-b, Physician, medical surgical services.

Reimbursement:

This service is reimbursed according to attachment 4.19-B.

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LIMITATIONS ON SERVICES (Cont.)

10. Dental Services

Coverage and provider qualifications are in accordance with 42 CFR 440.100 and 440.120. Some dental services require prior authorization such as: crowns; complete, immediate or partial dentures; oral surgical services; and orthodontics.

EPSDT Dental Services provided for recipients under age 21 are:

- a. Preventive services;
- b. Diagnostic services-dental examinations and radiology/diagnostic imaging that are dentally necessary;
- c. Restorative services -fillings, crowns;
- d. Periodontics;
- e. Removable Prosthodontics;
- f. Endodontics;
- g. Oral and Maxillofacial Surgery;
- h. Orthodontics;
- i. Adjunct services.

Dental services provided for recipients age 21 and older (including pregnant women) are:

- a. Preventive services;
- b. Diagnostic services-dental examinations and radiology/diagnostic imaging that are dentally necessary;
- c. Restorative services-amalgam and composite restorations, stainless-steel crowns;
- d. Periodontics-gingivectomy/gingivoplasty, scaling and root planning, full mouth debridement, periodontal maintenance;
- e. Removable Prosthodontics-full dentures, resin and interim partial dentures; relines and rebases; adjustments and repairs of dentures;

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LIMITATIONS ON SERVICES (Cont.)

10. Dental Services (Cont)

Dental services provided for recipients age 21 and older (including pregnant women) are (Cont):

- f. Endodontics-root canals on anterior and bicuspid teeth, therapeutic pulpotomy, pulpal debridement, retreatment of previous anterior root canal and apicoectomy/periradicular surgery;
- g. Oral and Maxillofacial Surgery;
- h. Adjunct services.

Additional services for pregnant women:

- a. Additional prophylaxis, fluoride and periodontal services if authorized as medically/dentally necessary due to the pregnancy;
- b. Permanent crowns and resin-based composite crowns for anterior teeth;
- c. Prefabricated post and core;
- d. Root canals on first molars;
- e. Apexification/recalcification, pulpal regeneration;
- f. Alveoplasty not in conjunction with extractions.

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LIMITATIONS ON SERVICES (Cont.)

11a. Physical Therapy

Coverage and provider qualifications are provided in accordance with 42 CFR 440.110(a). Physical therapy services require a plan of care for prior authorization of services. Initial evaluations and re-evaluations do not require prior authorization but are limited to: two initial evaluations in any 12-month period; and up to four re-evaluation services in any 12-month period. Additional evaluations may be provided with prior authorization. After evaluation, providers must submit a plan of care and documentation to the state. Based on the plan of care up to 30 visits per calendar year may be provided. Additional visits or modalities will be authorized based on medical necessity. Based on this Pre-payment Review (PPR), OHA will deny or approve payment of claims billed for the current plan of care episode. Prior Authorization is required beyond the initial limits of 30 rehabilitative visits and 30 habilitative visits in a calendar year. Coverage includes both rehabilitation and habilitation therapy, each with their own 30 visits per calendar year limits. Additional visits or modalities can be authorized due to medical necessity. Children under age 21 shall have additional visits authorized beyond these limits when medically appropriate. Physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist and must be in attendance while therapy treatments are performed. Services that are not covered: back school and back education classes, maintenance therapy, work hardening, or services that are not medically appropriate.

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LIMITATIONS ON SERVICES (Cont.)

11b. Occupational Therapy

Coverage and provider qualifications are in accordance with 42 CFR 440.110(b). Occupational therapy services require a plan of care for Pre-payment Review (PPR) of services. Initial evaluations and re-evaluations do not require prior authorization but are limited to two initial evaluations in any 12-month period: and up to four re-evaluation services in any 12-month period. Additional evaluations may be provided with prior authorization. After evaluation, providers must submit a plan of care and documentation to the state. Based on the plan of care up to 30 visits per calendar year may be provided. Additional visits or modalities will be authorized based on medical necessity. Based on this Pre-payment Review (PPR), OHA will deny or approve payment of claims billed for the current plan of care episode. Prior Authorization is required beyond the initial limits of 30 rehabilitative visits and 30 habilitative visits in a calendar year. Coverage includes both rehabilitation and habilitation therapy, each with their own 30 visits per calendar year limits. Additional visits or modalities can be authorized due to medical necessity. Children under age 21 shall have additional visits authorized beyond these limits when medically appropriate. Occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist and must be in attendance while therapy treatments are performed. Services that are not covered: back school and back education classes, maintenance therapy, work hardening, work hardening, or services that are not medically appropriate.

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LIMITATIONS ON SERVICES (Cont.)

11c. Services for Individuals with Speech, Hearing and Language Disorders

Coverage and provider qualifications are in accordance with 42 CFR 440.110 (c). Speech pathology or audiology services are provided according to a treatment plan of care. Initial evaluations and re-evaluations do not require prior authorization but are limited to: two initial evaluations in any 12-month period; and up to four re-evaluation services in any 12-month period. Additional evaluations may be provided with prior authorization. After evaluation, providers must submit a plan of care and documentation to the state. Based on the plan of care up to 30 visits per calendar year may be provided. Additional visits or modalities will be authorized based on medical necessity. Based on this Pre-payment Review (PPR), OHA will deny or approve payment of claims billed for the current plan of care episode. Prior Authorization is required beyond the initial limits of 30 rehabilitative visits and 30 habilitative visits in a calendar year. Coverage includes both rehabilitation and habilitation therapy, each with their own 30 visits per calendar year limits. Additional modalities can be authorized due to medical necessity. Children under age 21 shall have additional visits authorized beyond these limits when medically appropriate. Speech-language pathology may be performed by an individual licensed by the relevant state licensing authority to practice speech-language pathology. Audiology and hearing aid services may be performed by an individual licensed by the relevant state licensing authority to practice audiology and dealing in hearing aids. Services that are not covered: FM systems -- vibro-tactile aids; Earplugs; Tinnitus masker(s) or services that are not medically appropriate.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services-

/X/ Provided: /X/ No limitations / / With limitations*
/ / Not provided.

*Description provided on Attachment.

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LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

Reimbursement is available to covered outpatient drugs of any manufacturer that has entered into and complied with an agreement under Section 1927(a) of Title XIX of the Social Security Act, which are prescribed for a medically accepted indication. Drugs subject to limitations are those outlined under Section 1927(d)(4) of Title XIX of the Social Security Act.

Pursuant to 42 U.S.C. section 1396r-8, the State established a preferred drug list to be known as the Practitioner Managed Preferred Drug List (PDL). OHA determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

- Safety
- Potential for abuse or misuse
- Narrow therapeutic index
- High cost when less expensive alternatives are available

Prescribed Drugs may be subject to prior authorization by the agency to ensure that drugs are prescribed and dispensed appropriately and complies with requirements in Section 1927(d)(5) of the Act.

1935(d)(1) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1927(d)(2) and 1935(d)(2) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit–Part D.

The following excluded drugs are covered

(a) agents when used for anorexia, weight loss, weight gain:
Appetite Stimulants for Anorexia, Cachexia, Wasting.

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LIMITATIONS ON SERVICES (Cont.)

- 1927(d)(2) and 1935(d)(2) (b) agents when used to promote fertility
- (d) agents when used for the symptomatic relief
cough and colds: Cough Preparations/Expectorants
Cough & Cold Preps
- (e) prescription vitamins and mineral products, except prenatal
vitamins and fluoride:
- (f) nonprescription drugs:
Nonprescription drugs determined to be cost-effective and clinically
appropriate as approved by the Oregon Pharmaceutical &
Therapeutics Committee (aka DUR Board) can be found on the
Oregon Preferred Drug List on the OHA public website.
- (g) covered outpatient drugs which the manufacturer seeks to
require as a condition of sale that associated tests or monitoring services
be purchased exclusively from the manufacturer or its designee.

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LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

Supplemental Rebate Agreement:

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX under the national rebate program. Supplemental rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates received under the national rebate program.

CMS has authorized Oregon to enter into "The Sovereign States Drug Consortium (SSDC)" Medicaid Multi-State purchasing pool in relation to supplemental rebates.

The Centers for Medicare and Medicaid Services (CMS) has authorized a rebate agreement between the state and a drug manufacturer that provides supplemental rebates for drugs provided to the Oregon Medicaid program as follows:

- A supplemental rebate agreement submitted to CMS on 6/19/2003 and entitled, "State of Oregon, Supplemental Rebate Agreement" has been authorized by CMS.
- A supplemental rebate agreement submitted to CMS on 7/15/09, amended the 6/19/03 version of the "State of Oregon, Supplemental Rebate Agreement" under Transmittal 03-02, has been authorized by CMS.
- A supplemental rebate agreement submitted to CMS on 8/2/10 amended the 7/15/09 version of the "State of Oregon, Supplemental Rebate Agreement" authorized under Transmittal 09-05, has been authorized by CMS.
- CMS has authorized the state of Oregon to enter into outcome-based agreements with pharmaceutical manufacturers, on a voluntary basis, for drugs provided to Medicaid beneficiaries using the outcome-based supplemental rebate agreement beginning July 1, 2023.

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LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs (Cont)

Savings recognized from value-based purchasing and supplemental rebate agreements received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

The state will maintain the flexibility to negotiate supplemental rebate payments by manufacturers for Medicaid Managed Care Organization (MCO) utilization of products on the PDL regardless of whether the products are on the Medicaid MCO formularies (Version 1 of Attachment A, Transmittal 10-13).

TN No. 23-0024

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LIMITATIONS ON SERVICES (Cont.)

12.b. Dentures

Coverage and provider qualifications are in accordance with 42 CFR 440.100 and 440.120. Coverage for dentures and all dental services are as listed in this state plan under Attachment 3.1-A item 10. Dental services.

12.c. Prosthetic Devices

Medical equipment and appliances are provided when medically necessary and ordered by a treating physician or other licensed practitioner. The medical equipment or appliance must be approved for marketing and registered or listed as a medical device by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended.

Some prosthetic devices require prior authorization. These include but are not limited to lumbar orthotics, spinal orthotics, orthopedic shoe, shoulder-elbow orthotics. Oregon Medicaid does not cover items that are not medically necessary.

12.d. Eyeglasses

DMAP covers all vision services for children and pregnant women (including routine vision exams, fittings, repairs, and materials) provided by ophthalmologists, optometrists and opticians.

DMAP will not provide routine vision services and materials to adults 21 and over, except for clients with specific medical diagnoses.

Revision: HCFA-PM-85-3 (BERC)
May 1985

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b. Screening services.

// Provided: // No limitations // With limitations*
/X/ Not provided.

c. Preventive services.

/X/ Provided: // No limitations /X/ With limitations*
// Not provided.

d. Rehabilitative services.

/X/ Provided: // No limitations /X/ With limitations*
// Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: // No limitations /X/ With limitations*
// Not provided.

b. Skilled nursing facility services.

// Provided: // No limitations // With limitations*
/X/ Not provided.

c. Intermediate care facility services.

// Provided: // No limitations // With limitations*
/X/ Not provided.

* Description provided on Attachment.

TN No. 85-11

Supersedes

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13.c. Preventive Services

Coverage and provider qualifications are in accordance with 42 CFR 440.130.

Oregon covers all preventive services described in 45 CFR 147.130. These include:

- Services that are assigned a grade A and B rating by the United States Preventive Services Task Force (USPSTF),
- Immunizations listed on the immunization schedules of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings guidelines are provided based on the American Academy of Pediatrics Bright Futures periodicity schedule for screenings and follow up visits.
- With respect to women, evidence-informed preventive care and screenings provided are based upon Health Resources and Services Administration Women's Preventive Services guidelines as of 1/1/2017.

Preventive services are reimbursed according to the methodologies provided in Attachment 4.19-B under the following categories:

- Clinics
- Physicians
- Dentists
- Medical equipment and supplies
- Other licensed practitioners

The State will maintain documentation supporting expenditures claimed for these preventive services and ensure that coverage and billing codes comply with any changes made to the USPSTF or Advisory Committee on Immunization Practices (ACIP) recommendations.

Children under the age of 21 years will receive all medically necessary services without limitation in accordance with 1905(r) requirements. The service limitations delineated in Attachment 3.1-A do not apply to EPSDT recipients if the service is determined to be medically necessary by the Medical Assistance Programs medical or dental consultants.

TN 16-0010

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LIMITATIONS ON SERVICES (Cont.)

13.c. Preventive Services: Disease management services

Eligible clients are enrolled in the voluntary program and may “opt-out” or disenroll at any time. The Disease Management (DM) program adds additional services for individuals determined to be in groups with high-risk chronic and medical conditions. Individuals enrolled in the program maintain eligibility for state plan and waived services at all times. All DM services include professional medical risk assessments, evidence-based interventions that promote adherence to the clients medical treatment plan, education, counseling, direct assistance in the coordination of services with other systems and acute interventions as necessary will be provided by trained licensed Registered Nurse or other licensed care professional.

The Disease Management program is one-on-one interaction intended to provide evidence-based interventions that are both medically and psychosocially focused to those with chronic conditions and disease. Reduction of barriers to care is crucial to achieve improved health status. The DM program is designed to ensure that clients better understand and manage their chronic health condition(s) such as, but not limited to, asthma, diabetes, heart failure (CHF), coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD). The program does this by incorporating multiple levels of program modalities, along with collaborative healthcare practice models, evidence base guidelines, self-care management, lifestyle changes and adherence to a prescribed plan of care. The services offered to participants include medical assessments, goal oriented care plans, disease and dietary education, instruction in self management of the condition/disease and clinical outcome monitoring. These services utilize 24/7 Nurse Line and Audio Health Library. Mailings, outbound telephonic calls and Community Based RN service delivery are included. Each member receives a customized care plan developed based on gaps in the member’s knowledge. Once enrolled, a specially trained registered nurse conducts a comprehensive assessment to learn critical information about the member that will impact the care management approach for the member and may lead to an adjustment of the member’s risk profile. The assessment includes things such as, self-reported health care utilization, relevant co-morbidities, medication usage, functional, medical and psychosocial status, readiness to change and self-management and health maintenance practices or risk for non-adherence to recommended care. Additionally barriers to care are assessed and interventions to reduce or eliminate identified barriers are explored to allow the member to focus on improving their health status. Care plans are based on information obtained from the member, their provider treatment plan, and the member’s readiness to change. In addition to the condition-specific needs of the member, the care plan addresses co-morbidities and psychosocial issues; it is designed to ensure continuity, quality and effectiveness of care, Nurses monitor and measure member’s understanding and compliance with care plan goals at ongoing regular scheduled intervals and on member’s needs.

TN # 08-20

Date Approved 12/4/2008

Effective Date 3/1/09

Supersedes TN 08-06

Medical claims and pharmacy data are used in a predictive modeling process to achieve preliminary population-based risk stratification, from this information clients are identified for enrollment in the DM Program. Additionally, Clients may also be enrolled if the Client or the individual's Case Manager or physician requests enrollment.

Members and their personal physician are notified of the program through an outbound mail campaign. Then, specially trained professionals make outbound calls to enroll members into the care management program. A participant may request to opt-out of the program at any time, for any reason by calling the program 800 number, their self-sufficiency case worker, or the DMAP Client Advisory Service Unit. The member's status reason is changed to a "disenrolled" status in the disease management application to reflect this preference. However, the member still remains eligible to receive all other program level services such as the 24/7 Nurse Advice Line as members are maintained in the database so they can be easily re-enrolled at anytime at their request.

The State will contract with one or more Disease Management vendors, based upon region, who's trained registered nurses and other licensed health care professionals provide Disease Management services. All of the clients in the DM program have free choice of medical practitioners.

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13.c. Preventive Services: Doula services

Doula services include personal, support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. This includes emotional and physical support, provided during pregnancy, labor, birth and the postpartum period.

A doula's services includes the following:

- a) Provides prenatal counseling and assists the woman in preparing for and carrying out her plans for birth;
- b) Provider evidence-based information on health practices pertaining to pregnancy, childbirth, postpartum, newborn health, and family dynamics;
- c) Provide emotional support, physical comfort measures, and helps the woman get the information she needs to make informed decisions pertaining to childbirth and postpartum;
- d) Provides support for the whole birth team including a woman's partner and family members and hospital staff;
- e) Provides evidence-based information on infant feeding;
- f) Provides breastfeeding guidance and resources;
- g) Provides infant soothing and coping skills for the new parents;
- h) Provides postpartum support and honors cultural and family traditions;
- i) Facilitates and assures access to resources that can improve birth-related outcomes including transportation, housing, Alcohol, Tobacco and Drug cessation, WIC, SNAP, and intimate partner violence resources.

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13.c. Preventive Services: Doula services

Provider qualifications:

Pursuant to 42 CFR 440.130(c) doula services furnished shall be recommended by a physician or other licensed practitioner. Doula's must be certified and registered with the OHA, Office of Equity and Inclusion with approved curricula used to train birth doulas. To be certified as a birth doula an individual must: Complete all required training specified by OHA through an authority approved training program, complete an authority approved oral health training, be CPR-certified, document attendance at a minimum of three births and three post-partum visits.

Certification standards include the following:

- (a) A minimum of 28 in-person contact hours addressing the core curricula topics through an Authority approved training program for birth doulas or through another training program provided by a birth doula certification organization;
- (b) Six contact hours in cultural competency training; and
- (c) Six contact hours in one or more of the following topics as they relate to doula care:
 - (A) Inter-professional collaboration;
 - (B) Health Insurance Portability and Accountability Act (HIPAA) compliance; and
 - (C) Trauma-informed care.

Core curriculum:

All core curriculum for training birth doulas shall, at a minimum, introduce students to the key principles of the following topics:

- (a) Anatomy and physiology of labor, birth, maternal postpartum, neonatal transition, and breastfeeding;
- (b) Labor coping strategies, comfort measures and non-pharmacological techniques for pain management;
- (c) The reasons for, procedures of, and risks and benefits of common medical interventions, medications, and Cesarean birth;
- (d) Emotional and psychosocial support of women and their support team;
- (e) Birth doula scope of practice, standards of practice, and basic ethical principles;
- (f) The role of the doula with members of the birth team;

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13.c. Preventive Services: Doula services

Core curriculum (Cont):

- (g) Communication skills, including active listening, cross-cultural communication, and inter-professional communication;
- (h) Self-advocacy and empowerment techniques;
- (i) Breastfeeding support measures;
- (j) Postpartum support measures for the mother and baby relationship;
- (k) Perinatal mental health;
- (l) Family adjustment and dynamics;
- (m) Evidence-informed educational and informational strategies;
- (n) Community resource referrals;
- (o) Professional conduct, including relationship boundaries and maintaining confidentiality; and
- (p) Self-care.

Non-covered Services:

Travel time and mileage are not covered services.

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13.c. Preventive Services: Lactation Consultation services

Lactation Consultation services are intended for children in the post-partum period and their mothers who need help with breastfeeding. Services may be sought for difficulties such as inadequate milk supply, poor milk extraction, poor weight gain, nipple and breast pain, breast infections, and engorgement.

1. Services

Comprehensive lactation consultation must include the following:

- a. A face-to-face encounter with the mother and child lasting a minimum of thirty minutes
- b. Comprehensive maternal, infant and feeding assessment related to lactation
- c. Interventions at a minimum:
 - i. Observation of mother and child during breastfeeding
 - ii. Instruction in positioning techniques and proper latching to the breast
 - iii. Consultation in nutritive suckling and swallowing, milk production and release, frequency of feedings and feeding cues, expression of milk and use of pump if indicated, assessment of infant nourishment and reasons to contact a health care provider
- d. Information on community supports such as Women, Infant and Children (WIC)
- e. Evaluation of outcomes from interventions

2. Limitations

Lactation Consultation services is primarily intended for children age birth through ninety days postpartum or ninety days corrected for gestational age; however, it may be available to children up to age 21 when medically necessary. There is a limit of 5 Consultation sessions per child, and each session can last up to ninety minutes. In accordance with Section 1905(r) of the Social Security Act this service limit may be exceeded based on medical necessity.

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13.c. Preventive Services: Lactation Consultation services (Cont.)

3. Providers

a. The following providers may provide all lactation Consultation services without the addition of the Lactation Consultant licensure under Oregon State law: Physician, Nurse Practitioner (NP), Physician Assistant (PA), and Registered Nurse (RN).

b. Other providers not referenced above are required to be licensed as a Lactation Consultant under Oregon State law and hold a current and valid certification from the International Board of Lactation Consultant Examiners (IBLCE).

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13.c. Preventive Services: Newborn Nurse Home Visit

Newborn Nurse Home Visits

Coverage for Preventive services is in accordance with 42 CFR 440.130(c).

Newborn nurse home visits are a component of the services provided to families with newborns as part of the Universally offered Newborn Nurse Home Visiting Program.

Newborn Nurse Home Visits may include a support visit prior to the comprehensive newborn nurse home visit to address an urgent need, one comprehensive visit and up to two follow up support visits. The visits can be exceeded based on medically necessity in accordance with EPSDT. Nursing services provided include a comprehensive maternal and newborn physical assessment as appropriate for the visit type as well as standardized anticipatory and supportive guidance.

Program coverage:

A comprehensive newborn nurse home visit must be provided by a registered nurse in the family's home. The comprehensive newborn nurse home visit must include but is not limited to:

- (a) Maternal physical assessment (if applicable) according to clinical guidelines approved by the Authority.
- (b) Newborn physical assessment according to clinical guidelines approved by the Authority

Provider qualifications:

Newborn Nurse Home Visiting Services Providers must be certified by the Oregon Health Authority. Newborn Nurse Home Visiting services must be provided by a licensed registered nurse with experience in community health, public health, child health nursing.

Reimbursement:

This service is reimbursed according to attachment 4.19-B.

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13.c. Preventive Services: Community Violence Prevention Services

A. General Description:

Community violence prevention services are provided by a certified violence prevention professional (VPP) to a Medicaid beneficiary who has received treatment for an injury (which includes both medical and behavioral health treatment for a physical and/or behavioral health injury) sustained as a result of an act of community violence. Covered services are provided for the purpose of promoting improved health outcomes and positive behavioral change and preventing further violence. In accordance with 42 C.F.R. § 440.130(c), these services must be recommended by a physician or other qualified licensed practitioner of the healing arts within the practitioner's scope of practice under state law and are designed to prevent further impacts of community violence, prevent future community violence, prolong life, and promote the physical and mental health and efficiency of the individual

B. Service Description:

Community violence prevention services are evidence-based, trauma-informed, supportive and non-psychotherapeutic services provided by a certified violence prevention professional in any appropriate setting, for the purpose of promoting improved health outcomes and positive behavioral change, preventing further injury and future violence. The services are tailored for each person based on the individualized screening and assessment.

Covered services include: screening; assessment of needs; development of individualized service plan; peer support; counseling, including counseling to address and mitigate the impact of trauma; mentorship; conflict mediation; crisis intervention; patient education; discharge planning; and care coordination services that are part of the community violence prevention services and which facilitate the beneficiary's access to appropriate services, including medical, behavioral health, social, and other necessary services, all of which are designed to prevent further impacts of community violence, prevent future community violence, prolong life, and promote the beneficiary's physical and mental health in accordance with the individualized service plan.

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13.c. Preventive Services: Community Violence Prevention Services

C. Provider qualifications

OHA Certified Violence Prevention Professional (VPP) Training & Certification Program minimum curriculum requirements include: Effects of trauma & violence; trauma informed care; de-escalation; conflict mediation; retaliation prevention; case management; victim advocacy; and patient privacy. Thirty-five hours of initial, OHA approved, crisis intervention training and 6 hours of continuing education every 2 years.

D. Reimbursement

This service is reimbursed according to attachment 4.19-B.

(1) Medical/Social and Psychological Evaluations are:

- (a) ordered or prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice and as defined by state law;
- (b) provided by qualified professionals, e.g., medical evaluations are carried out by physicians or other licensed practitioners of the healing arts as defined by state law, psychological evaluations are carried out by licensed qualified psychologists and medical social histories are carried out by qualified social workers and medical or nursing personnel;
- (c) provided either directly by the facility or provided by other qualified professionals on a referral basis. Such evaluations must be ordered or prescribed by a physician or other licensed practitioners of the healing arts within the scope of his/her practice as defined by state law; other evaluation services such as speech and hearing evaluations and neurological evaluations are provided either directly by the facility or provider or by other qualified professionals on a referral basis;
- (d) directed toward the formulation of a diagnosis and/or treatment plan which specifies the type, amount and duration of treatment projected to remedy the defined physical or mental disorders or mental deficiencies of the patient.

(2) Comprehensive Treatment Plan is:

- (a) the development, periodic review and revision of the treatment plan under the direction of a physician or other licensed practitioner of the healing arts within the scope of his/her practice and as defined by state law from data contained in the medical/social and psychological evaluation which specifies the type and duration of treatment needed to remedy the defined physical or mental disorders or mental deficiencies of the patient.

(3) Psychotherapy Services include:

- (a) individual psychotherapy services when provided directly by a qualified staff member in accordance with the goals specified in a medical treatment plan written and ordered or prescribed by a physician or licensed practitioner of the healing arts as defined by state law:

- (b) group psychotherapy services when provided in accordance with goals specified in a written medical treatment plan as described in (a) above and limited to five (5) individuals per each staff person;
 - (c) patient centered family therapy services which include the recipient's family members and are delivered in accordance with goals as specified in a medical care treatment plan as described in (3)(a) above.
- (4) Developmental Therapy is:
- (a) treatment which is ordered or prescribed by a physician;
 - (b) provided directly by a qualified therapist;
 - (c) part of a treatment plan which specifies therapy modality and projected amount and duration of treatment to restore the patient to his optimal level of development;
 - (d) directed toward the rehabilitation of defined physical or mental disorders or mental deficiencies in the areas of sensomotor, communicative and effective development;
 - (e) there must be a minimum ratio of one (1) qualified therapist for every five (5) individuals involved in group developmental therapy.
- (5) Other Therapies are:
- (a) other therapies provided in accordance with a physician's authorized medical care treatment plan such as speech and hearing therapy, physical therapy and occupational therapy;
 - (b) provided by licensed staff members or other licensed professionals-on a referral basis.
- (6) Patient-centered Consultation is:
- (a) related to a specific patient;
 - (b) provided by a licensed or certified health professional staff member;
 - (c) provided in accordance with the physician authorized medical care plan to the staff of other agencies, other care/treatment providers and/or family members and others whose involvement and cooperation is important to the success of the treatment plan.
- (7) The maximum number of days allowed for a combination of all the services is limited to the prescription of the physician-approved treatment plan, and the contracted level of service.

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13.d. Rehabilitative: Mental Health Services

Mental health rehabilitative services include coordinated assessment, therapy, consultation, medication management, skills restoration and interpretive services. The Addictions and Mental Health Division (the Division) may provide these services in various settings, including residential. Each contract or subcontract provider of rehabilitative services establishes a quality assurance system and a utilization review process. Each contract or subcontract provider, in conjunction with a representative quality assurance committee, writes a quality assurance plan to implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based upon input from service providers, clients and families served, and client representatives.

The Division provides mental health rehabilitative services through approved Mental Health Organizations (MHOs), Coordinated Care Organizations (CCO), Community Mental Health Program (CMHPs) or through direct contracted providers. The MHOs, CCOs or CMHPs may provide services directly, or through subcontract providers, in a variety of settings. Mental health rehabilitation services must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for the maximum reduction of mental disability and restoration of a recipient to their best possible functional level.

Mental health rehabilitation service components include:

- Intake evaluation, assessment, screenings and brief intervention treatment;
- Crisis and Stabilization services;
- Individual, Group and Family level rehabilitative therapy;
- Medication management and monitoring;
- Intensive In-home Behavioral Health Services;
- Mental Health Services provided to children, adolescent and adults in Residential settings (includes intensive rehabilitative treatment);
- Peer Support;
- Rehabilitation Mental Health Care Coordination;
- Skills restoration.

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13.d. Rehabilitative: Mental Health Services (Cont)

Intake evaluation, assessment, screening and brief intervention treatment:

An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and free-standing evaluation and treatment. Routine services may begin before the completion of the intake once medical necessity is established. Coordinated assessments and screenings include the intake process of the individual, a mental health assessment resulting in a diagnosis and completion of an integrated service and support plan (ISSP) with the individual's input in setting their treatment goals. Individual Service and Support Plan (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the mental health assessment and the intended outcomes of treatment. Brief intervention treatment is a solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. This plan does not include assistance with self/care or life skills training. Enrollees may move from brief intervention treatment to longer term Individual Services at any time during the course of treatment. Duration/frequency of this service is determined by the individual's needs and documented in their ISSP. Providers authorized to provide these services include LMP, QMHP and mental health interns under appropriate supervision.

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13.d. Rehabilitative: Mental Health Services (Cont)

Crisis and Stabilization services:

Evaluation and treatment of mental health crisis to individuals experiencing a mental health crisis: A mental health crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow. Crisis services will be available where the individual is experiencing a mental health crisis on 24 hours a day, 7 days a week, 365 days per year basis and not restricted to select locations within any region on particular days or times and must address co-occurring substance use disorders, including opioid use disorder, if identified. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

Stabilization services include short-term flexible services, supports and coordination such as life skills training and understanding of medication effects to assist in stabilizing the individual in their community setting. These services are for individuals and families (services for the family are provided for the direct benefit of the beneficiary) continuing to exhibit patterns of behavioral and emotional dysregulation requiring continued intervention and coordination to maintain their baseline functioning and prevent future mental health crisis. Stabilization services are delivered in the community following a crisis event and development of a stabilization plan as coordinated by the mobile crisis team. The stabilization period may continue for up to 56 days; however, individual may at any time transfer to other long-term services and supports for continued care. This is not intended to be a limitation of any crisis or stabilization services, but part of a continuum of care based on the individual's and family's needs. Crisis and stabilization services will not be provided in an Institution of Mental Disease (IMD).

Crisis and stabilization services follow an integrated and culturally, linguistically, and developmentally appropriate trauma-informed approach and may be provided prior to an intake evaluation for mental health services. Providers authorized to provide these services include Licensed Medical Practitioners (LMP), Qualified Mental Health Professional (QMHP), Qualified Mental Health Associate (QMHA), Mental Health Interns, Certified Alcohol and Drug Counselor (CADC) and Peer Support Specialists under appropriate supervision. Refer to Attachment 3.1-A, section 13.d, page 6-d.6-6-d.- & 6-d.16 for provider qualifications.

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13.d. Rehabilitative: Mental Health Services (Cont)

Community Based Mobile Crisis Intervention Services:

Community based mobile crisis intervention services are focused, time limited, intensive, preventative, behavioral, rehabilitative interventions designed to specifically diffuse and mitigate a crisis. It involves all services, supports, and treatments necessary to provide a timely crisis response, crisis interventions such as de-escalation, and crisis prevention activities specific to the needs of the individual, in a way that is person and family centered. This service must address co-occurring substance use disorders, including opioid use disorder, if identified. At minimum, it includes the initial response of conducting immediate crisis screening and assessment, providing mobile crisis stabilization and de-escalation, and coordinating with and making referrals to health, social, and other services and supports as needed to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization. Services may also include follow up interventions for a period up to 72 hours after the initial response that provides, where appropriate, additional mobile crisis intervention services and de-escalation and coordination with and referrals to health, social, emergency management, and other services and supports as needed to effect symptom reduction and harm reduction. If continued stabilization services are identified after 72 hours, a stabilization plan must be developed for coordination with referrals for continued stabilization services. Community based mobile crisis response and stabilization may connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation only if situations warrant transition to other locations.

Community based mobile crisis intervention services also include maintaining relationships with relevant community partners, including law enforcement, medical, mental health, and addiction disorders providers, primary care providers, tribal communities, community health centers, crisis respite centers, and managed care organizations (if applicable). This work is done while ensuring the privacy and confidentiality of persons receiving mobile crisis intervention services.

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13.d. Rehabilitative: Mental Health Services (Cont)

Community based mobile crisis teams are provided by, at minimum, a two-person multidisciplinary team that includes at least one qualified professional able to conduct a mobile crisis screening and assessment within their scope of practice under state law and one other professional or paraprofessional with expertise in mental health services.

NOTE: Community based mobile crisis intervention services provided by mobile crisis teams provide services outside of a hospital or facility setting and are not intended to replace or terminate the need for further crisis, stabilization, or other services

Community based mobile crisis intervention services follow an integrated and culturally, linguistically, and developmentally appropriate trauma-informed approach and may be provided prior to completion of an intake evaluation. Providers authorized to provide these services include Licensed Medical Practitioners (LMP), Qualified Mental Health Professional (QMHP), Qualified Mental Health Associate (QMHA), Mental Health Interns, Certified Alcohol and Drug Counselor (CADC) and Peer Support Specialists under appropriate supervision. Refer to Attachment 3.1-A, section 13.d, page 6-d.6-6-d.- & 6-d.16 for provider qualifications.

Individual, Group and Family level rehabilitative therapy:

Therapy contains both individual and group psychotherapy in alignment with the stated goals in the ISSP to restore an individual's function. Services provided to individuals designed to assist in the attainment of goals described in the ISSP. Goals of Individual, Group or Family level treatment may include enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work, or educational environment.

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13.d. Rehabilitative: Mental Health Services (Cont)

Individual, Group and Family level rehabilitative therapy (Cont):

Individuals eligible for group therapy must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. Duration/frequency of this service is determined by the individual's needs and documented in their ISSP. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their ISSP. Providers authorized to provide these services include LMP, QMHP and mental health interns.

Medication management and monitoring:

The prescribing and/or administering and reviewing of medications and their side effects, includes both pharmacological management as well as supports and training to the individual. This service shall be rendered by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy. Also includes medication monitoring, reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. Time spent with the enrollee is the only direct service billable component of this modality. Duration/frequency of this service is determined by the individual's needs and documented in their ISSP. Providers authorized to provide these services include LMP, QMHP, QMHA and mental health interns.

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13.d. Rehabilitative: Mental Health Services (Cont)

Intensive In-home Behavioral Health Services provided to children, adolescents and young adults

A specialized combination of services provided to individuals under the age of 22 in the community or at the individual's home to provide for stabilization and long term treatment. These services may include a combination of individual and family therapy, skills restoration, medication management, peer support, care coordination, and in-person crisis response as indicated in the Person-Centered Service Plan. Services are intended to provide intensive interventions in the community and provide additional community based options to residential treatment. Providers authorized to provide these services include LMP, QMHP, QMHA, Peer Support Specialists and mental health interns.

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13.d. Rehabilitative :Mental Health Services (Cont)

Mental Health Services provided to children, adolescents and adults in Residential settings:

A specialized form of rehabilitation service in settings that are not comprised of institutions of more than 16 beds and primarily engaged in providing diagnosis, treatment or care of person with mental disease between the age of 22 and 64, that offers a sub-acute psychiatric management environment. Individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less intense treatment setting.

Individuals receiving this level of rehabilitative care receive services in a residential setting based on a plan of care designed with the intent to provide the setting and treatment for the individual to continue in recovery so they are ready to return to more independent and less restrictive treatment settings. Services are provided in Residential Treatment Facilities, Residential Treatment Homes and Adult Foster Homes licensed and certified by the Addictions and Mental Health Division of the Oregon Health Authority. These residential providers employ

A variety of mental health staff including licensed and non-licensed staff in compliance with the Integrated Service and Support Rule (ISSR) and provide services in an integrated team approach.

Therapeutic interventions may be performed in individual and group format in these settings. Services and providers included in this under this setting are the same as those described in the remainder of the rehabilitation section and include: Intake evaluation, assessment, screening, brief intervention treatment, crisis and stabilization services, individual, group, and family level rehabilitative therapy, medication monitoring, peer support, rehabilitation mental health case management and skills training.

Peer Support:

Peer services can be provided by peer counselors to individuals who are under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. Peer support services promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills in order to facilitate the recovery of other individuals with mental health and substance use disorders. Peer services include self-help support groups by sharing the peer counselor's own life experiences related to mental illness and will build support mechanisms that enhance the consumers' recovery and restores their ability to function in the community.

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13.d. Rehabilitative: Mental Health Services (Cont)

Peer Support (Cont):

These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, drop-in centers etc.). Services provided by peer counselors are described in the individualized ISSP which uses a person centered planning process to promote participant ownership of the plan of care and delineates specific goals.

Rehabilitation Mental Health Care Coordination:

To be eligible, the individual must be in need of care coordination in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned re-admission and to increase the community tenure for the individual. Providers authorized to provide these services include LMP, QMHP, QMHA, Peer Support Specialists and mental health interns.

Skills restoration:

Provides a range of integrated and varied life skills restoration (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) provided in a wide array of settings, including residential and outpatient, for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. Patients engage in their treatment as outlined in the ISSP and these services are restorative in nature. Duration/frequency of this service is determined by the individual's needs and documented in their ISSP. Providers authorized to provide these services include QMHP, QMHA, Peer Support Specialists and mental health interns.

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13.d. Rehabilitative: Mental Health Services (Cont)

Provider qualifications:

Providers outlined below are authorized to provide mental health rehabilitative services:

- A. Licensed Medical Practitioners (LMPs) provide ongoing medical oversight as appropriate. A Licensed Medical Practitioners (LMP) means a person who meets the minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:
1. Holds at least one of the following educational degrees and valid licensure:
 - a. Physician licensed to practice in the State of Oregon;
 - b. Advanced Practice Nurses including Clinical Nurse Specialist and Certified Nurse Practitioner licensed to practice in the State of Oregon; or
 - c. Physician's Assistant licensed to practice in the State of Oregon.
 2. Whose training, experience and competence demonstrates the ability to conduct a comprehensive mental health assessment and provide medication management, including a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon.
- B. "Clinical Supervisor" means a Qualified Mental Health Professional (QMHP) with at least two years of post graduate clinical experience in a mental health treatment setting who subscribes to a professional code of ethics. The clinical Supervisor, as documented by the LMHA, demonstrates the competency to oversee and evaluate the mental health treatment services provided by a QMHA or QMHP.

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13.d. Rehabilitative: Mental Health Services (Cont)

Provider qualifications (cont):

- C. "QMHP" must be licensed, or be employed by, or contract with, an organization that has obtained a certificate of approval from the Division for the scope of services to be reimbursed. QMHP is a Licensed Medical Practitioner or any other person meeting the following minimum qualifications as documented by the LMHA or designee:
1. Graduate degree in psychology;
 2. Bachelors degree in nursing and licensed by the State of Oregon;
 3. Graduate degree in social work;
 4. Graduate degree in a behavioral science field;
 5. Graduate degree in a recreational, art, or music therapy; or
 6. Bachelor's degree in occupational therapy and licensed by the state of Oregon;
 7. Licensed by the Oregon state Board of Psychologist examiners, Licensed Social Workers, Licensed Professional Counselors and Therapists; and
 8. Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi axial DSM diagnosis; write and supervise a treatment plan; conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of their training.
- D. "QMHA" means a person delivering services under the direct supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:
1. A bachelor's degree in a behavioral sciences field; or
 2. A combination of at least three year's relevant work, education, training or experience; and

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13.d. Rehabilitative: Mental Health Services (Cont)

Provider qualifications (cont):

3. Has the competencies necessary to:

- a. Communicate effectively;
- b. Understand mental health assessment, treatment and service terminology and to apply the concepts; and
- c. Provide psychosocial skills development and to implement interventions prescribed on a treatment plan within their scope of practice.

E. "Peer-Support" Specialist" means a person delivering services under the supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:

1. An Individual who has successfully completed training through a curriculum approved by AMH. This curriculum focuses on six (6) principles including:
 - Being culturally appropriate
 - Includes concepts of informed choice
 - Creating partnerships
 - Being person centered
 - Utilize strengths-based and trauma informed care concepts

Curriculum must contain the following specific elements, at a minimum:

- Communication skills and concepts
- Documentation skills and concepts
- Education specific to peer population and special needs of this population
- Knowledge of the recovery model and concepts of resiliency
- Ethics
- Knowing specific and applicable laws and regulations
- Knowing the related resources, advocacies and community support systems

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13.d. Rehabilitative: Mental Health Services (Cont)

Provider qualifications (cont):

And the individual:

1. Is a self-identified person currently or formerly receiving mental health services; or
 2. Is a self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
 3. Is a family member of an individual who is a current or former recipient of addictions or mental health services.
- F. "Mental Health Intern" means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:
1. be currently enrolled in a graduate program, for at least a master's degree, for degrees for psychology, social work or in a Bachelor of Science field.
 2. Has a collaborative educational agreement with the CMHP (provider) and the graduate program working within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider.
 3. Receives, at the minimum, weekly supervision, by a qualified clinical supervisor, employed by the provider of services.

LMPs, QMHPs, QMHAs, Peer Support Specialists and Mental Health Interns or other persons whose education and experience meet the standards and qualifications established by the Addictions and Mental Health Division of the Oregon Health Authority (OHA) through administrative rule may be authorized to deliver mental health treatment services as specified by the Division in support of mental health workforce shortages in certain areas of the state and engage alternative treatment delivery options such as telemedicine and remote video supported therapy.

Services are not provided to inmates of a public institution.

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13.d. Rehabilitative: Substance Use Disorder Services:

Substance Use Disorder (SUD) treatment services include; screening, assessment, individual counseling, group counseling, individual family and/or couple counseling, group family and/or couple counseling, care coordination, medication assisted treatment, medication management, collection and handling of specimens for substance analysis, interpretation services, acupuncture, detoxification and peer support.

Rehabilitative services must be recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under state law and that the purpose of the services is for the “maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level”.

SUD TREATMENT SERVICE COMPONENTS

Acupuncture is used in combination with counseling and behavioral therapies to reduce withdrawal symptoms, decreases SUDs cravings acupuncture is used as part of a comprehensive treatment plan, duration and frequency is determined by the service plan. Providers authorized to provide these services include Acupuncturist, LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

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13.d. Rehabilitative: Substance Use Disorder Services:

Assessment consists of gathering key information and engaging in a process with the individual that enables the healthcare professional to establish the presence or absence of a disorder, determine the individual's readiness for change, identify the individual's strengths or problem areas that may affect the processes of treatment and recovery. This process results in a diagnosis and completion of a service plan with the individual's input in setting their treatment goals. The duration/frequency of the treatment services are determined utilizing the service plan and the individual's needs. Providers authorized to provide these services include LMP, QMHP, CADAC and interns under appropriate supervision as defined in the provider qualification section.

Brief intervention is an early intervention, evidence-based practice designed to motivate individuals at risk of substance use disorder and related health problems to change their behavior through brief counseling sessions. Brief interventions can also be used to encourage those with more serious dependence or disorders to accept more intensive treatment. Brief interventions are intended to address problematic or risky substance use that presents with or without a previous diagnosis and will make appropriate referrals to services. Other activities include but are not limited to brief conversations on use of substances the effects of the use, discuss options for treatment and strategies to discontinue use or other harm reduction strategies. This may be provided before or after screenings or those already screened seeking treatment. Providers authorized to provide these services include LMP, QMHP, CADAC and interns, Certified Peers under appropriate supervision as defined in the provider qualification section.

Care coordination is to deliberately organize care and the sharing of information among all participants concerned with the care of the individual, the care team. Services are provided to an individual with complex needs in order to ensure timely and appropriate treatment and care. Activities include assessment and ongoing re-assessment, admission and discharge planning, patient/family education, effective and timely communication between care team, coordinate and manage care transitions between levels of care, assists in treatment goal planning, integrated treatment planning, resource identification, referral and linkage to rehabilitative services and informal resources such as family and self-help support, and collaborative development of individualized services that promote continuity of care, arrange for peer support, arrange for medical transportation. These specialized activities are intended to promote treatment retention and to minimize the risk of relapse and to increase the community tenure for the individual. Providers authorized to provide these services include LMP, QMHP, CADAC, Certified Peers and interns under appropriate supervision as defined in the provider qualification section.

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13.d. Rehabilitative: Substance Use Disorder Services:

Case management refer to Supplement 1 to Attachment 3.1-A of this state plan

Community integration and skills restoration provides a range of integrated and varied life skills restoration provided in a wide array of settings, including residential, community, and outpatient, for Medicaid enrollees intended to promote improved functioning, treatment retention and to minimize the risk of relapse and to increase the community tenure for the individual. Patients engage in their treatment as outlined in the individual's treatment and/or recovery plan and these services are restorative in nature. Activities to support life skills, and restoration to the community include but are not limited to self-care, medication management, reduction/elimination of maladaptive behaviors, skills to maintain household, health hygiene, nutritional issues etc. Duration/frequency of this service is determined by the individual's needs and documented in the individual's treatment and/or recovery plan. Providers authorized to provide these services include LMP, QMHP, QMHA, Certified Peer, and CHW.

Crisis and stabilization services provides evaluation and treatment of Substance Use to individuals experiencing a crisis. A Substance Use crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Stabilization services include short-term face-to-face assistance with life skills training and understanding of medication effects. This service includes a) follow up to crisis services; and b) other individuals determined by a Substance Use professional. Stabilization services may be provided prior to a screening or intake evaluation for Substance Use. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision.

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13.d. Rehabilitative: Substance Use Disorder Services:

Group counseling/ group family and/or couple counseling therapy services provided is designed to assist in the attainment of goals described in the service plan. Goals of Individual, Group or Family level treatment may include enhancing interpersonal skills, mitigating the symptoms of SUDs, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for group therapy must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. Duration/frequency of this service is determined by the individual's needs and documented in their service plan. Family treatment may take place without the consumer present in the room, but service must be for the benefit of attaining the goals identified for the individual in their service plan. Services to the beneficiary's family and significant others is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

Individual counseling therapy/individual family and/or couple counseling provides individual counseling therapy in a private setting as identified by their service plan. The duration/frequency of the treatment services are determined utilizing the service plan and the individual's needs. Services to the beneficiary's family and significant others is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

Medication assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs. MAT is clinically driven with a focus on individualized patient care identified in their service plan. Providers authorized to provide these services include LMP, QMHP, CADC. From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act."

For MAT specific to opioids use disorder refer to Supplement 5 to Attachment 3.1-A of this state plan.

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13.d. Rehabilitative: Substance Use Disorder Services:

Medication management is for the prescribing and/or administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. This service shall be rendered by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or care coordination managers, but includes only minimal psychotherapy. Also includes medication monitoring, reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. Duration/frequency of this service is determined by the individual's needs and documented in their service plan. Collection and handling of specimens for substance analysis are included in this service. From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

Peer support services are provided in accordance with SMDL #07-011. Services can be provided to individuals who are under the consultation, facilitation or supervision of a competent SUDs treatment professional who understands rehabilitation and recovery. Peer Support services promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills in order to facilitate the recovery of others with substance use disorders. Peer services include self-help support groups by sharing the peer counselor's own life experiences related to SUDs and will build support mechanisms that enhance the consumers' recovery and restores their ability to function in the community. . Services provided by peer supports are described in the individualized service plan which uses a person-centered planning process to promote participant ownership of the plan of care and delineates specific goals. Providers authorized to provide these services are Certified Peers as defined in the provider qualification section.

Screening is a brief process that occurs soon after the individual seeks services. It indicates whether the individual is likely to have a substance use disorder and mental disorder. Individuals who screen positive for substance use disorders are given a full in-depth assessment, those who screen positive for a mental disorder receive or are referred on to receive a full in-depth assessment. Providers authorized to provide these services include LMP, QMHP, CADC, Certified Peers and interns under appropriate supervision as defined in the provider qualification section.

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13.d. Rehabilitative: Substance Use Disorder Services:

Withdrawal management refers not only to the reduction of the physiological and psychological features of withdrawal syndromes, but also the process of interrupting the momentum of compulsive use. This service component is for ambulatory withdrawal management and non-ambulatory withdrawal management. Withdrawal management (ambulatory) is provided for mild withdrawal symptoms with or without extended on-site monitoring. Services offered at this level include individual assessment, medication or non-medication methods of withdrawal management, clinical monitoring of signs and symptoms of withdrawal, individual and group therapies. There are two types of non-ambulatory level of withdrawal management, the difference between these two types of levels is the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals. Non-ambulatory withdrawal management (clinically managed) is for moderate withdrawal symptoms that require 24-hour structure, support, supervision, and observation for individuals who are experiencing withdrawal symptoms. Emphasis is on peer and social support; this level of care does not require medical professionals. Providers include peer support and other non-clinical staff. Services offered at this level include daily clinical services to assess and address the needs of the individual, appropriate medical services, individual and group therapies, and withdrawal support.

Non ambulatory withdrawal Management (medically monitored) is for severe withdrawal symptoms and is delivered by licensed medical and nursing professionals, who have specialized training in substance use disorders, and provides 24-hour medically supervised evaluation and withdrawal management. This level of care is for individuals whose withdrawal signs and symptoms are sufficiently severe to require medical professionals but not an acute care general hospital. Services offered at this level include daily clinical services to assess and address the needs of the individual, appropriate medical services, individual therapy designed to enhance the individual's understanding of addiction and the completion of the withdrawal management process, and withdrawal support. Hourly nurse monitoring of the individual's progress and medication administration if needed. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

LIMITATION ON SERVICES

Limitation and duration/frequency of services are dependent upon each individual's medical needs and outlined in their service and/ or treatment plan. Medically necessary rehabilitative services are provided without limitation in amount, duration and scope in accordance with clinical treatment guidelines, indications and usage.

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PROVIDER QUALIFICATIONS

Providers outlined below are authorized to provide substance use disorder rehabilitative services:

- A. Licensed Medical Practitioners (LMPs) provide ongoing medical oversight as appropriate. A Licensed Medical Practitioner (LMP) means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:
 1. Holds at least one of the following educational degrees and valid licensure:
 - a. Physician licensed to practice in the State of Oregon;
 - b. Advanced Practice Nurses including Clinical Nurse Specialist; and Certified Nurse Practitioner licensed to practice in the State of Oregon; or
 - c. Physician's Assistant licensed to practice in the State of Oregon.
 2. Whose training, experience and competence demonstrates the ability to conduct a comprehensive mental health assessment and provide medication management, including a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon.
- B. "CADC" means a Certified Alcohol and Drug Counselor who is supervised by a LMP, QMHP or other QMHA:
 1. CADC I; requires education, supervised experience hours and successful completion of a written examination. 150 hours of Substance Use Disorder education provided by an accredited or approved body. 1,000 hours of Supervised Experience, Completion of the NCAC I professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors.
 2. CADC II; a minimum of a BA/BS degree, with a minimum of 300 hours of Substance Use Disorder education provided by an accredited or approved body. 4,000 hours of Supervised Experience, Completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors. Completion of the NAADAC Case Presentation Examination.
 3. CADC III; a Minimum of a master's degree with a minimum of 300 hours of Substance Use Disorder education provided by an accredited or approved body. 6,000 hours of Supervised Experience, Completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors. Completion of the NAADAC Case Presentation Examination.
 4. CADC must obtain a certificate of approval or license from the Division for the scope of services to be reimbursed.

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13.d. Rehabilitative: Substance Use Disorder Services (Cont)

Provider qualifications (cont):

C. "QMHP" means a Qualified Mental Health Practitioner must be licensed, or be employed by, or contract with, an organization that has obtained a certificate of approval from the Division for the scope of services to be reimbursed. QMHP is a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

1. Graduate degree in psychology;
2. Bachelor's degree in nursing and licensed by the State of Oregon;
3. Graduate degree in social work;
4. Graduate degree in a behavioral science field;
5. Graduate degree in a recreational, art, or music therapy; or
6. Bachelor's degree in occupational therapy and licensed by the state of Oregon;
7. Licensed by the Oregon state Board of Psychologist examiners, Licensed Social Workers, Licensed Professional Counselors and Therapists; and
8. Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi axial DSM diagnosis; write and supervise a treatment plan; conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of their training. Must also hold a Licensed or Certified in Alcohol and Drug Counseling.

In instances where a QMHP is not a LMP they are supervised by a LMP.

D. "QMHA" means a Qualified Mental Health Associate meaning a person delivering services under the direct supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:

1. A bachelor's degree in a behavioral sciences field; or
2. A combination of at least three year's relevant work, education, training or experience; and
3. Has the competencies necessary to:
 - a. Communicate effectively;
 - b. Understand mental health assessment, treatment and service terminology and to apply the concepts; and
 - c. Provide psychosocial skills development and to implement interventions prescribed on a treatment plan within their scope of practice.

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13.d. Rehabilitative: Substance Use Disorder Services (Cont)

Provider qualifications (cont):

4. Must also hold a Certification of Alcohol and Drug Counseling.

E. "Certified Peer/Peer-Support" Specialist" means a person delivering services under the supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:

1. An Individual who has successfully completed training through a curriculum approved by OHA.

This curriculum focuses on six (6) principles including:

- Being culturally appropriate
- Includes concepts of informed choice
- Creating partnerships
- Being person centered
- Utilize strengths-based care concepts
- Utilize trauma informed care concepts

Curriculum must contain the following specific elements, at a minimum:

- Communication skills and concepts
- Documentation skills and concepts
- Education specific to peer population and special needs of this population
- Knowledge of the recovery model and concepts of resiliency
- Ethics
- Knowing specific and applicable laws and regulations
- Knowing the related resources, advocacies and community support systems

And the individual:

1. Is a self-identified person currently or formerly receiving mental health services; or
2. Is a self-identified person in recovery from a substance use disorder; or
3. Is a family member of an individual who is a current or former recipient of addictions or mental health services.

Certified Peer/Peer Support Specialists require 20 hours of continuing education every three years.

TN 21-0012

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13.d. Rehabilitative Substance Use Disorder Services (Cont)

Provider qualifications (cont):

F. "Acupuncturist" provides health care using acupuncture and other forms of traditional Oriental Medicine. Acupuncture treats neurological, organic or functional disorders by stimulation of specific points on the surface of the body by insertion of needles. Licensure requirements include:

1. Graduated from an accredited acupuncture program
2. Had a current certification in acupuncture by the appropriate national commission.
3. Licensed by the Oregon Medical Board
4. Have a minimum of five years of licensed practice elsewhere in the United States prior to obtaining Oregon licensure status.

G. "CHW" means Community Health Worker means a person delivering services under the supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:

1. An Individual who has successfully completed training through a curriculum approved by OHA. This curriculum focuses on four (4) principles including:
 - Outreach and mobilization
 - Community Cultural Liaison
 - Case management, care coordination, and system navigation
 - Health Promotion and Coaching

H. "Intern" means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:

1. be currently enrolled in a graduate program, for at least a master's degree, for degrees for psychology, social work or in a Bachelor of Science field.
2. Has a collaborative educational agreement with the CMHP (provider) and the graduate program working within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider.
3. Receives, at the minimum, weekly supervision, by a qualified clinical supervisor, employed by the provider of services.

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13.d. Rehabilitative: Substance Use Disorder Services:

IMD ASSURANCE

Residential treatment services for SUDs are provided to Medicaid title XIX eligible individuals in facilities with 16 or fewer beds. Licensed SUD residential facilities with greater than 16 beds that meet the definition of “institution for mental diseases” IMDs (defined per 42 CFR 435.1010) are not permitted. Payment is excluded for individuals in “institutions of mental diseases” (IMDs) defined per 42 CFR 435.1010, except to the extent that the state is providing medical assistance to eligible pregnant and postpartum women outside of an IMD pursuant to section 1012 of the SUPPORT for Patients and Communities Act.

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13.d. Rehabilitative: Behavior Rehabilitation Services

Behavior Rehabilitation Services are provided to children/youth under age 21 to remediate debilitating psycho-social, emotional and behavioral disorders. To provide early intervention, stabilization, and development of individualized pro-social and productive coping skills upon the recommendation of a licensed practitioner of the healing arts within the scope of their practice within the law. Prior approval is required.

Service Description:

Behavior Rehabilitation Services may be provided in a variety of settings and consist of interventions to help children/youth acquire essential coping skills. Specific services may include the following: milieu activities, crisis intervention, regular scheduled face-face individual and group behavior remediation sessions, and skills training. The purpose of this service is to remediate specific behavioral symptoms or maladaptive behaviors which have been explicitly identified in an individualized written service plan that is regularly reviewed and updated. Client centered services may be provided individually or in groups and may include the child's/youth's biological, adoptive, or foster family. Services are provided for the direct benefit of the child/youth.

The services will include crisis intervention on a 24-hour basis to stabilize the child's/youth's behavior until resolution of the problem is reached, or until the child/youth can be assessed and treated by a Qualified Mental Health Professional or Licensed Medical Practitioner. Program Coordinators and Social Service Staff can provide this service.

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13.d. Rehabilitative: Behavior Rehabilitation Services (Cont)

Regular scheduled behavioral interventions are provided to remediate specific behavioral symptoms or maladaptive behaviors which have been explicitly identified in the service plan. Social Service Staff or Direct Care Staff under the supervision of a Social Staff person can provide this service. Counseling or treatment for behavioral health conditions should be provided by Qualified Mental Health Professionals or Licensed Medical Practitioners.

Skill training is provided to assist the child/youth in the development of individualized pro-social and productive responses to social and emotional behaviors, peer and family relationships, self-care, conflict resolution, aggression reduction, anger control, and to reduce or eliminate impulse and conduct disorders as identified in the service plan. Social Service Staff can provide this service

Milieu activities refer to those activities performed with children/youth to normalize their psycho-social development and promote the safety of the child/youth and stabilize their environment. The child/youth is monitored in structured activities which may be developmental, recreational, academic, rehabilitative, or a variety of productive work activities. As the child/youth is monitored, planned interventions are provided to remediate the identified behavioral symptoms or maladaptive behaviors and promote their replacement with more individualized pro-social and productive responses. Program Coordinators or Social Service can provide this service directly. Direct Care staff can provide this service under the supervision of a Program Coordinator or Social Service Staff.

Behavior Rehabilitation Services do not duplicate services available through any other Medicaid state plan authority or waiver.

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13.d. Rehabilitative: Behavior Rehabilitation Services (Cont)

Provider Qualifications :

Program Coordinator means a person who meets the following minimum qualifications

A Bachelor's Degree, preferably with major study in Psychology, Sociology, Social Work, Social Sciences, or a closely allied field, and two years' experience in the supervision and management of a program providing care and services to children, youth, or adults.

Social Service Staff means a person who meets the following minimum qualifications:

Master's Degree with major study in Social Work, Psychology, Sociology, Social Sciences, or a closely allied field and one year of experience working for a program providing care and services to children, youth, or adults. Or a bachelor's degree with major study in Social Work, psychology, Sociology, or a closely allied field and two years' experience working for a program providing care and services to children, youth, or adults.

Direct Care Staff means a person who meets the following minimum qualifications

Require that no less than 50% of the Child Care Staff in a facility have a bachelor's degree. Combination of formal education and experience working with children/youth may be substituted for a bachelor's degree. Direct Care Staff are members of the service team and work under the direction of a qualified Social Service staff or a Program Coordinator.

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(Reserved for future use)

14.a. Services for individuals age 65 or older in institutions for mental disease

Payments for persons age 65 or older in psychiatric hospitals will be made for individuals who have had a pre-admission screening except in an emergency, and certified eligible for payment by the Mental Health and Developmental Disability Services Division or its designee.

LIMITATIONS ON SERVICES

13.c. Preventive Services for HIV Infected Individuals

Coverage of HIV/AIDS Prevention Services are provided subject to OMAP rules.

HIV/AIDS Prevention Services are provided for individuals seeking HIV/AIDS counseling and testing services and to all HIV seropositive clients. These interventions aim to control and/or stop the spread of HIV/AIDS through prevention efforts and to prevent secondary or opportunistic infections. The services include the provision of medical services as well as the management of behavioral and nutritional factors and HIV-risk reduction techniques.

Providers of HIV/AIDS Prevention Services are trained and certified by the HIV/AIDS Prevention Services Program by the Oregon Health Division, following the protocols established by the Oregon Health Division for this program.

Revision:

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15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided No limitations With limitations*
 Not Provided.

b. Including such services in a public institution (or district part thereof) for the mentally retarded or

Provided No limitations With limitations*
 Not Provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided No limitations With limitations*
 Not Provided.

17. Nurse-midwife services.

Provided No limitations With limitations*
 Not Provided.

18. Hospice care (in accordance with section 1905(o) of the Act.

Provided No limitations
 Provided in accordance with section 2302 of the Affordable Care Act
 With limitations*
 Not Provided.

* Description provided on Attachment.

LIMITATIONS ON SERVICES

15.a. Intermediate Care Facilities' Services

Intermediate care facility services are provided subject to maximum cost reimbursement.

15.b. Intermediate Care Facilities for the Mentally Retarded or Persons with Related Conditions (ICF/MR)

Intermediate care facilities for the mentally retarded or persons with related conditions are provided within the limitations set forth in Oregon Administrative Rules 309-43-000 through 309-43-200.

16. Inpatient Psychiatric Facility Services for Individuals Under age 21

Payment for persons under age 21 in inpatient psychiatric facilities will be made for individuals who have had a pre-admission screening in accordance with 42 CFR 441 Subpart D, except in an emergency, and who are certified as eligible for payment by the Mental Health and Developmental Disability Services Division or its designee.

17. Nurse Midwife Services

Nurse Midwife and other services within the scope of practice of a licensed nurse practitioner are provided on the same basis as physician services.

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18. Hospice Care in accordance with section 1905(o) of the Act.

Hospice care is provided in accordance with the State Medicaid Manual at section 4305. Hospice services include acute, respite, home care and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of the patient during the final stages of illness, dying and bereavement period.

Covered services are intermittent except during brief periods of acute symptom control. Core services are provided directly by hospice agency staff or contracted through a hospice agency and include:

- Physician services related to administration of the plan of care;
- Nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN;
- Medical social services provided by a social worker under the direction of a physician;
- Counseling services provided to a client and the client's family members or caregivers.

Additional services, which must be related to the hospice diagnosis, written in the plan of care, identified by the hospice interdisciplinary team, safe and meet the client's needs within the limits of the hospice program, and made available by the hospice agency on a 24-hour basis. This includes, but is not limited to, pain and symptom management and palliative services.

Hospice coverage is available for two (2) 90-day election periods followed by an unlimited number of subsequent 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care. An election period to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency; and
- Does not revoke the election.

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18. Hospice Care in accordance with section 1905(o) of the Act.

A Hospice agency is required to be a Medicare, Title XVIII- certified hospice and currently licensed by the Oregon Health Authority, Public Health Division. All practitioners who provide hospice services must be licensed, certified, accredited, or registered according to Oregon State's laws and rules, including but not limited to physicians, registered nurses, licensed practical nurses, and social workers.

Concurrent care for children on hospice in accordance with section 2302 of the Affordable Care Act. Hospice clients 20 years of age and under may elect hospice without foregoing curative services to which the client is entitled for treatment of the terminal condition.

Revision: HCFA-PM-94-4 (MB)
APRIL 1994

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19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations
 Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

 Provided: With limitations*
X Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

- Additional coverage ++

- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on Attachment.

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LIMITATIONS ON SERVICES

20. Extended Services to Pregnant Women

- a. Pregnancy-related and post-partum services provided for 60 days after the pregnancy ends include:

Maternity management and support services:

Service description:

Maternity Case Management (MCM) are services to optimize pregnancy outcomes, including reducing the incidence of low birth weight babies. MCM services are tailored to the individual's needs and consist of:

- Case management: Assist and support an individual pregnant client in accessing necessary health, nutritional and other services, includes assessment and the development of a Client Service Plan (CSP);
- Nutritional assessment and counseling provided by a licensed or a registered dietician;
- Child birth counseling services.

- b. Services for any other medical conditions that may complicate pregnancy include:

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AUGUST 1991

Transmittal #91-25
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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a ~~qualified~~ provider (in accordance with section 1920 of the Act).
eligible

// Provided // No limitations // With limitations*
/x/ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

// Provided // No limitations // With limitations*
/x/ Not provided

23. Certified Pediatric or family nurse practitioners' services.

// Provided // No limitations /X/ With limitations*

*Description provided in Attachment.

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LIMITATIONS ON SERVICES

23. Nurse Practitioner Services

1. Services within the scope of practice of a licensed nurse practitioner are provided on the same basis as physician services.

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June 2001

Transmittal #01-14
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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
 Provided No limitations With limitations*
 Not Provided:
 - b. Services provided in Religious Nonmedical Health Care Institutions.
 Provided No limitations With limitations*
 Not Provided:
 - c. Reserved
 - d. Nursing facility services for patients under 21 years of age.
 Provided No limitations With limitations*
 Not Provided:
 - e. Emergency hospital services.
 Provided No limitations With limitations*
 Not Provided:
 - f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
 Provided No limitations With limitations*
 Not Provided:

*Description provided on Attachment.

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LIMITATIONS ON SERVICES (Cont.)

24.a. Transportation

Emergency Ambulance transportation is provided as a mandatory medical service covered under the Medical Assistance Program. Emergency Ambulance does not require a Prior Authorization

Non-Emergent Medical Transportation provided as described in 3.1-D of the State Plan.

Transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day when both the SBHS covered service and the need for medically necessary transportation are included in the child's IEP/IFSP and the transportation provided is adapted to serve the needs of the disabled child pursuant to 42 CFR 440.170 (a)(1). An IEP should include only specialized services that a child would not otherwise receive in the course of attending school.

Transportation may also be billed to Medicaid when a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP, and when a child receives a Medicaid covered IDEA service at an off-site facility or is transported to a provider in the community.

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24. f. Personal Care Services (42 CFR 440.167)

“Personal Care Services” means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

- 1) Authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by the State;
- 2) Provided by an individual who is qualified to provide such services and who is not a member of the individual’s immediate family (described as spouses of recipients and parents of minor recipients – including stepparents who are legally responsible for minor children – as defined in Oregon law); and
- 3) Furnished in the home or other community locations outside the home.

For purposes of this section, family member means a legally responsible relative.

Scope of Services

Personal Care Services include a range of assistance, as developmentally appropriate, provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks, which they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing (redirecting) so that the person performs the task by him or herself.

Personal care assistance most often relates to performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs include; eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include; personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions.

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24. f. Personal Care Services (42 CFR 440.167)

Scope of Services (cont)

Skilled services delegated by a Registered Nurse (RN) under Oregon's Nurse Practice Act may be considered personal care services when the RN provides appropriate training and delegation of the listed nursing tasks in accordance with the Oregon Nurse Practice Act.

Cognitive Impairments

An individual may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal assistance may include cueing along with supervision to ensure that the individual performs the task properly.

Freedom of Choice

The State assures that the provision of services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

Personal Care Services Include:

Activities of Daily Living (ADLs)

- Eating - is assisting the individual in feeding or fluid intake by any means from a receptacle into the body. Includes monitoring to prevent choking or aspiration.
- Bathing- is assisting the individual with cleansing the body, washing hair, shaving, nail care, and using assistive devices when necessary to get in and out of the bathtub or shower.
- Dressing- is assisting the individual with putting on, fastening, and taking off all items of clothing, braces, and artificial limbs, including obtaining and replacing items from their storage area in the immediate environment.

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24. f. Personal Care Services (42 CFR 440.167)

Activities of Daily Living (cont)

- Toileting- is assisting the individual in getting to and from, on and off, the toilet, commode or bedpan for elimination of feces and urine. This includes cleansing after elimination, and adjusting clothing as necessary.
- Maintaining Continence- includes external cleansing of Foley catheter, emptying catheter drainage bag, maintenance bowel care, changing and replacing incontinence products, including colostomy, or ileostomy bags.
- Transferring- is assisting the individual with mobility, transfers and repositioning by any means including use of an assistive device and includes turning or adjusting padding for physical comfort or pressure relief and encouraging or assisting with range of motion exercises.

Instrumental Activities of Daily Living (IADLs)

- Personal Hygiene- perform or assist with activities required to keep one's appearance neat, secure clothing, comb/brush hair, nail care, foot care, skin care, mouth care and oral hygiene, etc.
- Light Housework- perform or assist with housekeeping tasks necessary to maintain the individual in a healthy and safe living environment.
- Laundry- perform or assist with laundering or cleaning of clothing, bedding and other linens.
- Meal preparation- perform or assist with healthy meal planning and preparation, insuring special diets are followed.
- Transportation- assist individual in getting to and from necessary appointments and community activities through available means of transportation.
- Grocery Shopping- perform or assist individual in planning for and purchasing basic needs and household items.
- Using the Telephone- perform or assist individual in arranging necessary appointments and making desired phone calls.

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24. f. Personal Care Services (42 CFR 440.167)

Instrumental Activities of Daily Living (cont)

- Medication Management- assist with medications which are ordinarily self-administered. Includes administering medication, observation to insure individual is taking medication as ordered, documenting and monitoring any notable side effects, and refilling prescriptions in a timely manner. Assist with use, maintenance, and cleaning of in-home equipment, monitoring client's condition, ordering and maintaining necessary supplies.
- Money Management- perform or assist with budgeting, making payments for monthly expenses and use of personal funds for desired items and activities.

Delegated Nursing Tasks

- Dressing Changes – using sterile technique to prevent possibility of infection. Sterile dressing changes are required for a central line, or an open unhealed surgical site.
- Oxygen Administration - during regular intervals, and with daily unplanned changes. Oxygen administration requires an attending physician's order, which includes oxygen flow and method of administration. Frequently oxygen administration is changed based on oxygen saturation levels and/or physical symptoms (e.g., shortness of breath, breathing difficulties, cyanosis.).
- Pulse Oximeter Placement and Monitoring - monitor oxygen saturation levels and adjust the oxygen as necessary to keep within acceptable parameters established by the attending physician.
- Apnea Monitoring – Apnea monitors are used after oxygen desaturation or episodes of apnea or respiratory distress have occurred. Monitors are frequently used for infants experiencing opiate withdrawal and being dosed with a respiratory suppressant such as Morphine.
- Tracheotomy Care – daily cleansing of stoma, changing dressing, and observing site for signs of irritation, inflammation, or infection. Tracheostomy tubes must be changed periodically as ordered by the attending physician.

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24. f. Personal Care Services (42 CFR 440.167)

Delegated Nursing Tasks (continued)

- Oral Suctioning – to prevent aspiration due to gastroesophageal reflux and or copious oral secretions.
- Ventilator Care - changing ventilator tubing and connections, monitoring and changing ventilator settings (oxygen level, positive end expiratory pressure, peak flow, and/or intermittent mandatory ventilation, as ordered by the attending physician.
- Continuous Positive Airway Pressure (CPAP) - placement and monitoring of CPAP or canula and ensuring the mask is maintained during sleeping hours.
- Injections (subcutaneous) – given in the subcutaneous tissue to deliver medications such as Insulin, Growth Hormone, Epinephrine (for allergic reactions) and Glucagon (for hypoglycemic episodes in diabetics).
- Blood Glucose Testing – using lancet to prick the finger (or other area such as the forearm) to obtain a blood sample to determine the blood glucose level (using a Blood Glucose Monitor).

The services described in this section are not intrinsic elements of Title IV-E foster care maintenance payments.

For individuals under 21 years of age, services will be provided in accordance with EPSDT requirements at 1905(r), subject to determination of medical necessity and any prior authorization by the Department.

Personal Care Assessments

Assessments are performed on all clients prior to receiving personal care services to determine their level of need. Those clients receiving services that require nurse delegation are assessed by a Registered Nurse (OAR 411-034-0070). For children receiving personal care services in a foster care setting, all personal care assessments are performed by a Registered Nurse (OAR 413-090-0133). Personal Care Services are available to all qualifying Medicaid-eligible individuals, including children who are not in a foster care setting.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS ON SERVICES

24. f. Personal Care Services (42 CFR 440.167)

Qualified Provider

Personal care services provided to qualifying Medicaid-eligible children not served in a foster care setting, seniors, and people with disabilities, including those people with addiction and mental health disabilities must be provided by a qualified provider as described in OAR 411-034-0050.

In summary, the rule requires that a Qualified Provider:

- Is a person who, in the judgment of the Department or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized;
- Must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007;
- Paid by the Department must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative;
- Must be authorized to work in the United States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and immigration rules;
- Must be 18 years of age or older. A Homecare Worker enrolled in the Client-Employed Provider Program who is at least sixteen years of age may be approved for limited enrollment as a qualified provider, as described in OAR 411-031-0040(8)(d);
- May be employed through a Contracted In-Home Care Agency or enrolled as a Homecare Worker or Personal Care Attendant under an individual provider number. Rates for these services are established by the Department; and
- Homecare Workers enrolled in the Client-Employed Provider Program providing State Plan Personal Care services must meet all of the standards in OAR chapter 411, division 031.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS ON SERVICES

24. f. Personal Care Services (42 CFR 440.167)

Qualified Provider (cont)

- Criminal History Re-checks:
 - Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007.
 - Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department.
 - The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment. Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated.

For children receiving personal care services in a foster care setting:

- Provider qualifications are outlined in Oregon Administrative Rule 413-090-0110 (13) effective 12/29/09. "Qualified Provider" means an individual who:
 - Is authorized by the Department through the contract Registered Nurse of Personal Care RN Manager;
 - Demonstrates to the RN or Personal Care RN Manager their skills, abilities and capability to safely and adequately provide the authorized personal care services;
 - Maintains a drug-free household;
 - Has been approved through the background check process described in Child Welfare Policy I-G.1.4, "Oregon Computerized Criminal History Checks and Nationwide Criminal History Checks through the FBI for Relative Caregivers, Foster Parent, Other Persons in Household and Adoptive Parents for Children in the Care or Custody of DHS"; and
 - Is not a legally responsible relative of the child or young adult eligible for personal care services.
- The contract RN or Personal Care RN Manager makes the determination of whether the provider has the skills, abilities and capabilities to safely and adequately provide the authorized personal care services as described in the personal care services plan (OAR 413-090-0135).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS ON SERVICES

24. f. Personal Care Services (42 CFR 440.167)

Eligible individuals must be assessed for their need for personal care services. Personal care services are not to exceed 270 hours per year. Individuals whose assessed need exceeds the 270-hour annual limit may receive approval for additional hours through a prior approval process. State Plan Personal Care services are not available for individuals in an institution.

State OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

 provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (c) furnished in a home.

X Provided: X State Approved (Not Physician) Service Plan Allowed
 X Services outside the Home Also Allowed
 X Limitations Described on Attachment

 Not Provided.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1915(j) Self-Directed Personal Assistance Services

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically
Needy

X Self-Directed Personal Assistance Services, as described in Supplement 3 to Attachment
3.1-A.

X Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the
State elects Self-Directed Personal Assistance Services as a State Plan service delivery
option.

_____ No election of Self-Directed Personal Assistance Services: By virtue of this submittal,
the State elects not to add Self-Directed Personal Assistance Services as a State Plan
service delivery option.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: No limitations With limitations None licensed or approved

Please describe any limitations: Facilities must be approved and licensed by the Oregon Health Authority, Public Health Division; and Maintain standards required by the Division for licensure under Chapter 333 Division 076 OAR.

29. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations With limitations (please describe below)

Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: Limited to services within the recognized providers scope of practice. Practitioners as referenced in (a) & (b) below

Please check all that apply:

- (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
- (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *
- (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: Licensed Direct Entry Midwives (non R.N.)

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management-Child Welfare Youth

Target Group:

Targeted case management services are provided to all Medicaid eligible recipients under age 21 who are currently residing in an in-home setting; a foster home; group home; residential care facility (excludes Institutions for Mental Disease and Public Institutions as defined in 42 CFR 435.1010); or independent living situation under the responsibility of the Child Welfare division of the Department of Human Services (DHS) or the Oregon Youth Authority (OYA).

Areas of state in which services will be provided:

- Entire State
 Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs:

These annual assessment (more frequent with significant change in condition) activities include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM-Child Welfare Youth (Continued)

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

To help an eligible individual obtain needed services including activities that help link and individual with:

- Medical, social, educational providers; or
- Other programs and services capable of providing needed services (including food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM-Child Welfare Youth (Continued)

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Provider Organizations must be certified as meeting the following criteria:

- A minimum of three years experience of successful work with children and families, involving a demonstrated capacity to provide all core elements of case management, including Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment;
- A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population;
- A minimum of three years experience working with the target population;
- Administrative capacity to ensure quality of services in accordance with state and federal requirements;
- Financial management system which provides documentation of services and costs.
- Capacity to document and maintain individual case records in accordance with state and federal requirements;
- Demonstrated commitment to assure a referral consistent with section 1902a(23), freedom of choice of providers;
- A minimum of three years experience demonstrating capacity to meet the case management service needs of the target population.

Case Managers within Provider Organizations must meet the following criteria:

- Completion of training in case management;
- Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders;
- Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication;
- Ability to work with court systems, to learn state and federal rules, laws and guidelines relating to child welfare, and to gain knowledge about community resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM-Child Welfare Youth (Continued)

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)

The name of the individual;

(ii) The dates of the case management services;

(iii) The name of the provider agency (if relevant) and the person providing the case management service;

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM-Child Welfare Youth (Continued)

Case Records (42 CFR 441.18(a)(7))-continued:

- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;
- (vii) A timeline for obtaining needed services;
- (viii) A timeline for reevaluation of the plan.

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

CASE MANAGEMENT SERVICES

HIV/AIDS

Target Group:

The "target" group for this amendment shall consist of individuals who are eligible for Title XIX Medical Assistance Coverage as categorically eligible and who meet the following criteria:

- Have a documented HIV infection or a diagnosis of AIDS, *whether symptomatic or asymptomatic*.
- Are receiving case management services from providers who are licensed or certified by the Oregon Department of Human Services (DHS), and provide service under contract to the DHS Division of Medical Assistance Programs (DMAP).

The target group will not include individuals under age 65 residing in an institution for Mental Disease (IMD) or individuals involuntarily living in secure custody of law enforcement, judicial or penal systems.

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to ____ consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

CASE MANAGEMENT SERVICES

Definition of services:

HIV/AIDS case management is defined as services furnished to assist individuals living with HIV or AIDS, eligible under the State Plan, in obtaining timely and coordinated access to needed medical, psycho-social, educational and other services, with the goal of improving overall health and well-being.

Within HIV case management, the case manager plays a pivotal role in assuring that the patient has access to and adheres to the treatment schedules and care services recommended by authorized providers. Case Management includes the following service categories:

Assessment and periodic reassessment of individual needs: This activity consists of interactive interviews and evaluations performed by the case manager that would occur at least annually to determine the need for any medical, educational, psycho-social or other services. These interviews primarily involve the gathering of information from the eligible individual but will also include the collection of information from other sources such as family members, medical providers, social workers, and educators, as necessary, to form a complete assessment of the individual. Through the assessment, the case manager is able to collect, analyze, synthesize and prioritize information which identifies individuals needs, resources, and strengths. These assessment activities include:

- Evaluation of individual's history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and related documentation;
- Evaluation of the capacity of the individuals to meet their personal needs and adhere to service advice and recommendations made;
- Evaluation of the capacity of the individual's social network and available human services agencies/ organizations to address the eligible individual's needs;
- Reevaluation of individuals to identify unresolved and or emerging needs, to guide appropriate revisions in the care plan (Reassessment).

Development (and periodic revision) of a specific care plan:

All eligible individuals of case management will have a current care plan developed and mutually agreed upon by both the case manager and the individuals (or the individual's authorized health care decision maker). The care plan:

- Is based on the information collected through the assessment;
- Specific documentation of goals and actions needed to address the medical, psycho-social, educational, and other services needed by the individual;
- Clear course of action to respond to the assessed needs of the eligible individual;
- Identification of at least one self-management goal to be included in their Care Plan;
- Documentation of the individual's success in achieving their self-management goal(s).

CASE MANAGEMENT SERVICES

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link and individual with:
- Medical, social, educational providers; or
- Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services, assist in scheduling appointments for the individual as needed;
- Remind and motivate individual to adhere to the treatment and care services schedules established by providers;

Monitoring and follow-up activities:

This consists of case management activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs. The level and frequency of monitoring and follow-up activities is determined through the use of an HIV-specific acuity scale and contact may be with the individual, family members, providers, or other entities or individuals to determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Eligible individual is adhering to the medical treatment, psycho-social and education services that have been recommended and authorized as part of the care plan;
- Changes in the needs or status of the individual, if any, are appropriately reflected through necessary adjustments in the care plan and service arrangements with providers.

Case management may include:

- Contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services.

CASE MANAGEMENT SERVICES

Qualifications of providers:

The minimum education or qualification requirements for case managers authorized to provide HIV case management through this amendment are as follows:

1. Oregon licensed registered nurse (RN) or
2. Bachelor of Social Work, or other related health or human service degree from an accredited college or university

Additionally, all case managers must have documented evidence of completing the Department of Human Services (DHS), HIV Care and Treatment-designated HIV Case Manager Training to be considered as a licensed provider of case management services. Furthermore, all HIV case managers are expected to participate in DHS-designated on-going training for case managers.

Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan[Section 1902(a)(19)];
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services[Section 1902(a)(19)];
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan [42 CFR 431.10(e)].

CASE MANAGEMENT SERVICES

Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. (2001 SMD)
- Activities integral to the administration of foster care programs; or (2001 SMD)
- Activities for which third parties are liable to pay. (2001 SMD)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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CASE MANAGEMENT SERVICES

Targeted Case Management- Early Intervention/Early Childhood Special Education (EI/ECSE)
Under The Individuals with Disabilities Education Act (IDEA)

Target Group: The state plan recognizes the target group as children with disabilities (birth until eligible for kindergarten) eligible under the IDEA attending Oregon's programs for EI (birth to 3yrs.) or ECSE (age 3 until eligible for kindergarten), and eligible for Medicaid under the state plan.

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g) (1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a) (10) (B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Case management services are services furnished to assist children with disabilities eligible for EI/ECSE services in the target group, eligible under the State Plan, in gaining access to needed medical,

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Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management-EI/ECSE-(continued)

Definition of services, Cont: social, educational, developmental and other appropriate services in coordination with the child's Individualized Family Service Plan (IFSP) developed and implemented pursuant to IDEA. Case Management includes the following:

Comprehensive assessment and periodic reassessment of eligible child's needs: Assessment activities are conducted as needed, but at a minimum at least once annually to review and revise a child's service coordination/ case management services.

These assessment activities include:

- Taking an eligible child's history;
- Assessment of the extent and nature of eligible child's needs (medical, social, educational, and other services);
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), for the child's case management needs; and
- Completing related documentation.

Development (and periodic revision) of a specific care plan in coordination with the child's IFSP that is based on the information collected through the assessment process that includes the following;

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible child;
- Includes activities such as ensuring the active participation of the eligible child's family (or authorized health care decision maker) and others to determine and develop goals; and
- Identifies an appropriate course of action with the family, authorized health care decision maker, community resources, and other IFSP team members to respond to the identified needs of the eligible child.

Referral and related activities: These activities assist an eligible child to obtain needed services, including activities that:

- Link an individual with medical, social, educational providers; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management-EI/ECSE-(continued)

Referral and related activities, Cont:

- Other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services;
- Assist in scheduling appointments for the eligible child as needed;
- Inform and encourage the eligible child's family to access available services;
- Completing related documentation.

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the eligible child's needs. The activities, and contact, may be with the eligible child, his or her family members, IFSP team members, providers, other entities or individuals. These monitoring and follow up activities in coordination with the eligible child's IFSP are conducted as needed; including at least once annually to review and revise a child's service coordination/case management services but may be conducted as frequently as necessary to help determine whether the following conditions are met:

- Services are being furnished in accordance with the eligible child's care plan in coordination with the child's IFSP;
- services provided in support of the child's care plan are adequate; and
- The service coordinator/targeted case manager in consultation with the family and other IFSP team members, make adjustments as needed in the care plan for new or additional arrangements to adequately meet the eligible child's needs.

Case management may include:

Contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible child to access services; identifying needs and supports to assist the eligible child in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible child's needs as identified in 42 CFR 440.169(e).

Qualifications of providers (42 CFR 441.18(a) (8) (v) and 42 CFR 441.18(b)):

EI/ECSE TCM Supervisors of service coordination/targeted case management services must:

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CASE MANAGEMENT SERVICES

Targeted Case Management-EI/ECSE-(continued)

Qualifications of providers, Cont:

- Possess a minimum of a master's degree; and
- Hold a Teacher Standard and Practices Commission (TSPC) administrative endorsement; or
- Authorization as an Early Childhood Supervisor.

EI/ECSE Specialists/Related Services Personnel/Service Coordinators/Targeted Case Managers must:

- Possess a minimum of a baccalaureate degree; and
- Hold a Teacher Standard and Practices Commission (TSPC) licensure; or
- State licensure or TSPC licensure in an area of related services and a professional development plan based on the content of EI/ECSE competencies; or
- Endorsement in EI/ECSE or related field; or
- Authorization as an Early Childhood Specialist.

In addition to the above, all must be employees of the Oregon Department of Education (ODE), its contractors or subcontractors; and have demonstrated knowledge and understanding about:

- Service coordination to assist clients in gaining access to needed medical, social, educational, or other services;
- The Oregon EI/ECSE programs;
- The Individuals with Disabilities Education Act (IDEA);
- The nature and scope of services available under the Oregon EI/ECSE programs.

Freedom of Choice (42 CFR 441.18(a) (1) :

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

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Targeted Case Management-EI/ECSE-(continued)

Freedom of Choice Exception (§1915(g) (1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a) (2), 42 CFR 441.18(a) (3), 42 CFR 441.18(a) (6) :

The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

- (i) The name of the individual;
- (ii) The dates of the case management services;

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CASE MANAGEMENT SERVICES

Targeted Case Management-EI/ECSE-(continued)

Case Records -Cont(42 CFR 441.18(a)(7)):

- (iii) The name of the provider agency (if relevant) and the person providing the case management service;
- (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;
- (vii) A timeline for obtaining needed services;
- (viii) A timeline for reevaluation of the plan.

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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CASE MANAGEMENT SERVICES

Targeted Case Management-Substance Use Disorder

Target Group:

Medicaid eligible individuals with substance use disorder or substance misuse/abuse.

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs:

These assessment activities include:

- Taking client history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and completing related documentation;

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CASE MANAGEMENT SERVICES

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Reevaluation (reassessment) of individual will occur at a minimum on an annual basis or as needed to identify unresolved and or emerging needs, to guide appropriate revisions in the care plan (Reassessment).

Development (and periodic revision) of a specific care plan: The care plan will be based on the information collected through the assessment and will include the following:

- Specifies the goals and actions needed to address the medical, psycho-social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identify a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (Such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that help link and individual with medical, social, educational providers; or
- Other programs and services that are capable of providing needed services (including food vouchers, transportation, child care and housing assistance to address identified needs and achieve goals specified in the care plan;

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Case management may include contact with non-eligible individuals, which are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

CASE MANAGEMENT SERVICES

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case Manager:

Case managers will possess a combination of education and experience necessary to support case planning, referral and client monitoring to effectively engage individuals who are identified as having potential substance abuse issues, substance use disorder, or conditions that are lacking readiness to engage in active treatment. This experience will demonstrate an understanding of issues relating to substance misuse/abuse, as well as needed community supports and linkages that will enable the individual to prepare for treatment, enter into treatment and/or remain engaged in treatment.

The Department will authorize behavioral health programs that are licensed, certified or have received a letter of approval from the Health System Division. Case managers may provide these services if employed by the program holding a letter of approval from the Health System Division and must have oversight by a clinical supervisor employed by the program. Qualified Case Managers must meet the following qualifications as outlined in Oregon Administrative Rule:

1. Licensed Medical Providers, Qualified Mental Health Professionals, Qualified Mental Health Associates; or
2. Who possess certification as an Alcohol and Drug Counselors (CADC) levels I, II or III; or
3. Have completed a Peer Services Training Program following a training curriculum approved by the Addictions and Mental Health Division and is:
 - a. A self-identified person currently or formerly receiving mental health services; or
 - b. A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
 - c. A family member of an individual who is a current or former recipient of addictions or mental health services.

CASE MANAGEMENT SERVICES

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management services (including targeted case management) will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services;
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

- (i) The name of the individual;
- (ii) The dates of the case management services;
- (iii) The name of the provider agency (if relevant) and the person providing the case management service;
- (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;
- (vii) A timeline for obtaining needed services; (viii) A timeline for re-evaluation of the plan.

CASE MANAGEMENT SERVICES

Limitations:

Case Management does not include the following:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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CASE MANAGEMENT SERVICES

Targeted Case Management-Tribal members

Target Group:

The target group consists of Medicaid eligible individuals served by tribal programs within the State of Oregon, or receiving services from a Federally recognized Indian tribal government located in the State of Oregon, and not receiving case management services under other Title XIX programs. The target group includes elder care; individuals with diabetes; children and adults with health and social service care needs; and pregnant women. These services will be referred to as Tribal Targeted Case Management Services. This amendment does not include case management services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

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CASE MANAGEMENT SERVICES

Targeted Case Management-Tribal members (continued)

Comprehensive assessment and periodic reassessment of individual needs:

These annual assessment (more frequent with significant change in condition) activities include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

To help an eligible individual obtain needed services including activities that help link and individual with:

- Medical, social, educational providers; or
- Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

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CASE MANAGEMENT SERVICES

Targeted Case Management-Tribal members (continued)

Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Provider Organizations must be certified as meeting the following criteria:

- A minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including:
- Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment;
- A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population;
- Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements;
- Maintain a sufficient number of case managers to ensure access to targeted case management services.

Case Managers within Provider Organizations must meet the following criteria:

- Completion of training in a case management curriculum;
- Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, and issues around aging;
- Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication;
- Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources.

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

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CASE MANAGEMENT SERVICES

Targeted Case Management-Tribal members (continued)

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)

The name of the individual;

(ii) The dates of the case management services;

(iii) The name of the provider agency (if relevant) and the person providing the case management service;

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

(v) Whether the individual has declined services in the care plan;

(vi) The need for, and occurrences of, coordination with other case managers;

(vii) A timeline for obtaining needed services;

(viii) A timeline for reevaluation of the plan.

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CASE MANAGEMENT SERVICES

Targeted Case Management-Tribal members (continued)

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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CASE MANAGEMENT SERVICES

Targeted Case Management
Public Health Nurse Home Visiting,
Expanded Babies First CaCoon and Nurse-Family Partnership

Target Group:

Targeted case management (TCM) services will be provided to Medicaid eligible perinatal women, infants and children through four years of age who have one or more risk factors for poor perinatal, birth and other poor health outcomes, or parent of said child listed in Table 1. For the purposes of this State Plan Amendment, *Perinatal* is defined as the period inclusive of pregnancy through two years postpartum, to the child’s second birthday. Services to a parent (primary caregiver) could be available during this same two year period following the birth of the child.

TCM services will also be provided to Medicaid eligible Children and Youth with Special Health Care Needs (CYSHCN), up to age 21, who have one or more diagnosis or very high risk factor listed in Table 2 below. Children with Special Health Care needs are “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”.

Table 1

Perinatal and Parental Eligibility Criteria
Pregnant woman with chronic health condition that places perinatal-infant outcomes at high risk (e.g., diabetes, hypertension, obesity, cognitive impairment, malignancy, asthma, HIV, seizure disorder, renal disease, systemic lupus erythematosus)
Pregnant woman with complications of pregnancy (e.g., preterm labor, multiple gestation, infections, oligohydramnios, polyhydramnios)
Pregnant woman with inadequate prenatal care
Pregnant woman with history of poor birth outcomes (e.g., preterm delivery, low birth weight infant, birth anomaly, fetal chromosomal abnormality, intrauterine growth restriction (IUGR), other complication to infant)
Perinatal woman with history of child abuse
Perinatal woman with tobacco use (current or recent within one year)
Perinatal woman with substance use/abuse includes any teratogenic substance (e.g., alcohol, opioids, current or recent within one year)

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CASE MANAGEMENT SERVICES

Table 1 (Cont)

Perinatal and Parental Eligibility Criteria
Perinatal woman with mental health condition
Perinatal woman experiencing intimate partner violence (current or recent within one year)
Perinatal woman of race/ethnicity with established health inequities (includes refugees)
Perinatal woman with inadequate resources to meet basic needs (e.g., shelter, food, utilities)
Perinatal woman with exposure to environmental hazards
Perinatal woman age 18 years or less
Perinatal woman who has not completed high school
Perinatal woman experiencing an unsupportive partner, and/or lack of social supports
Perinatal woman with history of incarceration
Pregnant woman who meets Nurse-Family Partnership (NFP) evidence based eligibility criteria, as defined by the NFP National Service Office
Parent of eligible child

Table 2

Infant and Children Eligibility Criteria (one or more criteria are required)	Diagnosis (Birth – to 21 yrs)
Infant born to mother enrolled in Expanded Babies First! or Nurse-Family Partnership	Endocrine disorders, e.g. diabetes
Referral from medical provider or social services for nurse home visiting	Malignancy
Teratogen exposed infant exposed infant (e.g., alcohol, opioids)	Cardiovascular disorders
	Chronic orthopedic disorders
Infant HIV positive	Neuromotor disorders including cerebral palsy and brachial palsy
Maternal PKU or HIV positive	Cleft lip and palate and other congenital defects of the head, face

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CASE MANAGEMENT SERVICES

Table 2 (Cont)

Infant and Children Eligibility Criteria (one or more criteria are required)	Diagnosis (Birth – to 21 yrs)
Intracranial hemorrhage grade I or II	Genetic disorders, e.g. cystic fibrosis, neurofibromatosis
Seizures or maternal history of seizures	Multiple minor anomalies
Perinatal asphyxia	Metabolic disorders (e.g., PKU)
Small for gestational age	Spina bifida
Very low birth weight (1500 grams or less)	Hydrocephalus or persistent ventriculomegaly
Mechanical ventilation for 72 hrs or more prior to discharge	Microcephaly and other congenital or acquired defects of the CNS
Neonatal hyperbilirubinemia	Hemophilia
Congenital Infection (TORCHS)	Organic speech disorders
CNS infection	Hearing loss
Head trauma or near drowning	Traumatic brain injury
Failure to grow	Fetal alcohol spectrum disorder
Suspect vision impairment	Autism, autism spectrum disorder
Family history of childhood onset hearing loss	Behavioral or mental health disorder WITH developmental delay
Prematurity	Chromosomal disorders
Lead or other environmental exposure	Positive newborn blood screen
Suspect hearing loss	HIV, seropositive conversion
Other risks for growth and development delay	Visual Impairment
Social Determinants of Health	Very High Medical Risk Factors
Maternal age 18 years or less	Intraventricular hemorrhage (grade III or IV) or periventricular leukomalacia (PVL) or chronic subdurals
Parents with cognitive impairment	Perinatal asphyxia accompanied by seizures
Parental substance use/abuse (e.g., alcohol, opioids current or recent within one year)	Seizure disorder
Parent did not complete high school	Oral-motor dysfunction requiring specialized feeding program (including gastrostomy)

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CASE MANAGEMENT SERVICES

Table 2 (Cont)

Social Determinants of Health	Very High Medical Risk Factors
	Chronic lung disorder
Parent with inadequate resources to meet basic needs for housing, food, shelter, utilities.	Suspect neuromuscular disorder
Parent with mental health condition	Developmental Risk Factors
Parent with history of abuse or neglect (child welfare agency involvement)	Developmental Delay
Parent experiencing intimate partner violence, current or within one year	Other
Parent with history of incarceration	Other chronic conditions not listed

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

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CASE MANAGEMENT SERVICES

Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs:

These annual assessment activities (more frequent with significant change in condition) include:

- Taking and evaluating client history;
- Identify and evaluating the extent and nature of individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
- Annual review or more often as indicated by change in individual needs.

Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that includes the following:

- Specifies the goals and actions to address the medical, psycho-social, educational, and other services needed by the eligible individual;
 - Includes activities such as ensuring the active participation of the eligible individual, working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (Such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, that are capable of providing needed support services (including but not limited to food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan;

Monitoring and follow-up activities: Activities and contacts necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring. Monitoring and follow-up activities are ongoing and include:

- Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision maker(s), family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the service plan is effectively implemented;

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State/Territory: OREGON

CASE MANAGEMENT SERVICES

Monitoring and follow-up activities (Cont):

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- Frequency of monitoring is based on the documented client needs.

Case management includes contacts with non-eligible individuals, who are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers:

Public Health Nurse (Expanded Babies First/CaCoon, Nurse-Family Partnership) Targeted Case Managers may be an employee of a Local County Health Department, under the jurisdiction of the Local Public Health Authority or other public or private agency contracted by a Local Public Health Authority. The case manager must be:

- A licensed registered nurse with experience in community health, public health, child health nursing;
- A Community Health Worker, Family Advocate or Promotora working under the supervision of a licensed registered nurse.

The minimum qualifications of the Community Health Workers, Family Advocates or Promotoras are as follows: High School Graduate, or GED with additional course work in human growth and development, health occupations or health education and two years' experience in public health, mental health or alcohol drug treatment settings, or any satisfactory combination of experience and training which demonstrates the ability to perform case management duties. The case manager must work under the policies, procedures, and protocols of the state Maternal and Child Health Program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

Qualifications of providers (Cont):

Provider organizations must be certified by the single state agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
 - a. Comprehensive client assessment
 - b. Comprehensive care/service plan development
 - c. Linking/coordination of services
 - d. Monitoring and follow-up of services
 - e. Reassessment of the client's status and needs
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. A sufficient number of staff to meet the case management service needs of the target population.
5. An administrative capacity to insure quality of services in accordance with state and federal requirements.
6. A financial management capacity and system that provides documentation of services and costs.
7. Capacity to document and maintain individual case records in accordance with state and federal requirements.
8. Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.
9. Ability to link with the Maternal and Child Health program Data System.

Freedom of Choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management services (including targeted case management) will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

- (i) The name of the individual;
- (ii) The dates of the case management services;
- (iii) The name of the provider agency (if relevant) and the person providing the case management service;
- (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;
- (vii) A timeline for obtaining needed services;
- (viii) A timeline for reevaluation of the plan.

Limitations:

Case Management does not include the following:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

Limitations (Cont):

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management

Developmentally Disabled Comprehensive Waiver, Model Waivers and TCM-only

Waiver Case Management (WCM) through the 1915(b)(4) -DD waiver replaces this State Plan Amendment for Targeted Case Management effective 7/1/13.

TN 13-10

Approval Date:8/22/13

Effective Date: 7/1/13

Supersedes TN 08-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

(Reserved for future use)

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State/Territory: OREGON

CASE MANAGEMENT SERVICES

(Reserved for future use)

TN 13-10
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

(Reserved for future use)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management

Developmentally Disabled Self Directed Support Services Waiver Only

Waiver Case Management (WCM) through the 1915(b)(4) -DD waiver replaces this State Plan Amendment for Targeted Case Management effective 7/1/13.

TN 13-10

Supersedes TN 09-07

Approval Date: 8/22/13

Effective Date: 7/1/13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

(Reserved for future use)

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State/Territory: OREGON

CASE MANAGEMENT SERVICES

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

(Reserved for future use)

TN 13-10.
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Approval Date: 8/22/13

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management-Children, Adults and Families (CAF) Self sufficiency

Target Group:

Medicaid eligible parents age 14 and over who receive Temporary Assistance to Needy Families (TANF) benefits.

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM- CAF Self sufficiency-Continued

Comprehensive assessment and periodic reassessment of individual needs:

These annual assessment (more frequent with significant change in condition) activities include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

To help an eligible individual obtain needed services including activities that help link and individual with:

- Medical, social, educational providers; or
- Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance program
State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM- CAF Self sufficiency-Continued

Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified by the Oregon Medicaid Single State Agency as qualified to provide case management services to this target group. The criteria for qualifying as a provider are as follows:

Provider Organizations:

- Demonstrated ability to provide all core elements of Case Management through at least three years of prior experience.
- Demonstrated ability to coordinate and link community resources required through at least three years of prior experience.
- At least three years experience with the target group.

Provider Organizations (cont):

- Sufficient staff and/or agreements with community organizations to have the administrative capacity to ensure quality of services in accordance with state and federal requirements.
- Financial management system which provides documentation of services and costs.
- Capacity to document and maintain individual case records in accordance with state and federal requirements.
- Demonstrated ability to assure referrals consistent with section 1902(a)(23), freedom of choice of providers.
- Ability to provide linkage with other case managers to avoid duplication of Case Management services.
- Ability to determine that the client is included in the target group.
- Ability to access systems to track the provision of services to the client.

Qualifications of Case Managers:

- Completion of training in case management curriculum.
- Basic knowledge of behavior management techniques.
- Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication.
- Knowledge of state and federal requirements related to the teen parents/JOBS program.
- Ability to use community resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM- CAF Self sufficiency-Continued

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities Program or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)

The name of the individual;

(ii) The dates of the case management services;

(iii) The name of the provider agency (if relevant) and the person providing the case management service;

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

(v) Whether the individual has declined services in the care plan;

(vi) The need for, and occurrences of, coordination with other case managers;

(vii) A timeline for obtaining needed services;

(viii) A timeline for reevaluation of the plan.

TN No. 10-01

Approval Date: 1/18/17

Effective Date: 1/1/10

Supersedes TN No. 93-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

CASE MANAGEMENT SERVICES

TCM- CAF Self sufficiency-Continued

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management- Healthy Homes Program

Target Group:

Services will be provided to Medicaid eligible children with poorly controlled asthma or a history of environmentally induced respiratory distress which can result in a life threatening asthma exacerbation or exacerbation of respiratory distress.

Risk Factors for the target group could include, but are not limited to:

- (a) Unscheduled visits for emergency or urgent care
- (b) one or more in-patient stays
- (c) history of intubation or Intensive Care Unit stay
- (d) a medication ratio of less than or equal to .33
- (e) environmental or psychosocial concerns raised by medical home
- (f) exceeds two days of school loss per year
- (g) inability to participate in sports and other activities
- (h) homelessness or inadequate housing/heat/sanitation

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Multnomah and Klamath Counties.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management- Healthy Homes Program

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs:

These annual assessment (more frequent with significant change in condition) activities include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, housing, environmental, including assessment for risk of lead exposure and existence of second hand smoke and other specified asthma triggers and irritants, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management- Healthy Homes Program

Development (and periodic revision) of a specific care plan that (Cont):

- specifies the goals and actions to address the medical, social, educational, housing, environmental (including lead abatement and removal of second hand smoke and other specified asthma triggers and irritants) and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

To help an eligible individual obtain needed services including activities that help link an individual with:

- Medical, social, educational, housing, environmental providers (including specialists for lead testing and removing specified asthma triggers and irritants); or
- Printed materials and websites; or
- Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.

Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Targeted Case Management- Healthy Homes Program

Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

(1) Healthy Homes – Targeted Case Management (TCM) providers must meet the following criteria:

- (a) Demonstrated capacity to provide all core elements of case management services including:
 - Comprehensive nursing assessment or environmental assessment;
 - Comprehensive care/service plan development;
 - Linking/coordination of services;
 - Monitoring and follow-up of services;
 - Reassessment of the client's status and needs.
- (b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population;
- (c) Demonstrated experience with the target population;
- (d) A sufficient number of staff to meet the case management service needs of the target population;
- (e) An administrative capacity to ensure quality of services in accordance with state and federal requirements;
- (f) A financial management capacity and system that provides documentation of services and costs;
- (g) Capacity to document and maintain individual case records in accordance with state and federal requirements, including HIPPA Privacy requirements;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Stat/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management- Healthy Homes Program

Qualifications of providers (Cont)

- (h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program;
- (i) Enrolled as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(2) The case manager must be a licensed registered nurse, registered environmental health specialist, asthma educator certified by the National Asthma Education and Prevention Program, community health worker certified in the Stanford Chronic Disease Self-Management Program, or worker working under the supervision of a licensed registered nurse or a registered environmental specialist.

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management- Healthy Homes Program

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

- (i) The name of the individual;
- (ii) The dates of the case management services;
- (iii) The name of the provider agency (if relevant) and the person providing the case management service;
- (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;
- (vii) A timeline for obtaining needed services;
- (viii) A timeline for reevaluation of the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Targeted Case Management- Healthy Homes Program

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

Targeted Case Management
Family Connect® Nurse Home Visiting

Target Group:

Targeted case management (TCM) services will be provided to Medicaid eligible infants 0 through 6 months of age.

For case management services provided to individuals in medical institutions:

Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)
Baker, Benton, Clatsop, Crook, Deschutes, Gilliam, Hood River, Jefferson, Lincoln, Linn, Malheur, Marion, Wasco, Washington, Wheeler and Sherman County

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

TN 21-0002

Approval Date: 3/24/21

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Supersedes TN 20-0012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

CASE MANAGEMENT SERVICES

Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs:

These annual assessment activities (more frequent with significant change in condition) include:

- Taking and evaluating client history;
- Identify and evaluating the extent and nature of individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
- Annual review or more often as indicated by change in individual needs.

Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that includes the following:

- Specifies the goals and actions to address the medical, psycho-social, educational, and other services needed by the eligible individual;
 - Includes activities such as ensuring the active participation of the eligible individual, working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (Such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, that are capable of providing needed support services (including but not limited to food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan;

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Monitoring and follow-up activities:

Activities and contacts necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring. Monitoring and follow-up activities are ongoing and include:

- Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision maker(s), family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the service plan is effectively implemented;
- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers;
- Frequency of monitoring is based on the documented client needs.

Case management includes contacts with non-eligible individuals, who are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers:

Family Connects® Nurse Home Visiting Targeted Case Managers may be an employee of a Local County Health Department, under the jurisdiction of the Local Public Health Authority or other public or private agency contracted by a Local Public Health Authority. The case manager must be:

- A licensed registered nurse with experience in community health, public health, child health nursing;
- A Community Health Worker, Family Advocate or Promotora working under the supervision of a licensed registered nurse.

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Qualifications of providers (cont):

The minimum qualifications of the Community Health Workers, Family Advocates or Promotoras are as follows: High School Graduate, or GED with additional course work in human growth and development, health occupations or health education and two years' experience in public health, mental health or alcohol drug treatment settings, or any satisfactory combination of experience and training which demonstrates the ability to perform case management duties. The case manager must work under the policies, procedures, and protocols of the state Maternal and Child Health Program.

Provider organizations must be certified by the single state agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
 - a. Comprehensive client assessment;
 - b. Comprehensive care/service plan development;
 - c. Linking/coordination of services;
 - d. Monitoring and follow-up of services;
 - e. Reassessment of the client's status and needs.
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. A sufficient number of staff to meet the case management service needs of the target population.
5. An administrative capacity to insure quality of services in accordance with state and federal requirements.
6. A financial management capacity and system that provides documentation of services and costs.
7. Capacity to document and maintain individual case records in accordance with state and federal requirements.
8. Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.
9. Ability to link with the Maternal and Child Health program Data System.

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Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management services (including targeted case management) will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

- (i) The name of the individual;
- (ii) The dates of the case management services;
- (iii) The name of the provider agency (if relevant) and the person providing the case management service;
- (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;
- (vii) A timeline for obtaining needed services;
- (viii) A timeline for reevaluation of the plan.

Limitations:

Case Management does not include the following:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

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Limitations (cont):

- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

TN 19-0003

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Effective Date: 07/01/19

Supersedes TN NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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Name and address of State Administering Agency, if different from the State Medicaid Agency.
Oregon Department of Human Services, 500 Summer St. NE, Salem, OR 97301

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

- A. The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 and CFR 435.218). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: Groups as provided under 42 CFR 435.236 Individuals in institutions who are eligible under a special income group with income under 300% of SSI).

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

Spousal impoverishment eligibility rules apply.

- B. The State determines eligibility for PACE enrollees under rules applying to institutional groups but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.
- C. The State determines eligibility for PACE enrollees under rules applying to institutional groups and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver 0185.R05.01.

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Regular Post Eligibility

1. SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

- (a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. The following standard included under the State plan (check one):

- (a) SSI
(b) Medically Needy
(c) The special income level for the institutionalized
(d) Percent of the Federal Poverty Level: _____%
(e) Other (specify): _____

2. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

3. The following formula is used to determine the needs allowance: _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. SSI Standard
2. Optional State Supplement Standard
3. Medically Needy Income Standard
4. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
5. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

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6. The amount is determined using the following formula: The amount allowed in Sec. 1924 of the Act _____
7. Not applicable (N/A)

(C.) Family (check one):

1. AFDC need standard
2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. The amount is determined using the following formula:

6. Other
7. Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. N/A 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

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(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. The following standard under 42 CFR 435.121:

2. The Medically needy income standard

3. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5. The amount is determined using the following formula:

6. Not applicable (N/A)

(C.) Family (check one):

1. AFDC need standard

2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

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4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. The amount is determined using the following formula:
6. Other
7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A) The following standard included under the State plan (check one):

1. SSI
2. Medically Needy
3. The special income level for the institutionalized
4. Percent of the Federal Poverty Level: _____%
5. Other (specify

(B) The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

(C) The following formula is used to determine the needs allowance: _____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

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II. Rates and Payments

- A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.
1. Rates are set at a percent of fee-for-service costs
 2. Experience-based (contractors/State's cost experience or encounter date)(please describe)
 3. Adjusted Community Rate (please describe)
 4. Other (please describe)

The acute care portion of the Amount Would Otherwise Have Paid (AWOP) is based on the fee-for service claims data and the managed care encounter data. The long-term care portion of the AWOP is based on fee-for-service claims data and some costs that are not in the MMIS database. Once the AWOP is developed each portion is set at different percentages of the AWOP.

B. The State Medicaid Agency assures that the rates are set in a reasonable and predictable manner by the Oregon DHS/OHA Actuarial Services Unit, using cost/eligibility data from within the three calendar years (or plan years, if different) prior to the year in which rate calculations are being performed.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

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III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

Program of All-inclusive Care for the Elderly (PACE) Rate Methodology and Amount That Would Have Otherwise Been Paid (AWOP) Calculation

The following information discusses the benefits, data, assumptions, and methods used for the Amount That Would Have Otherwise Been Paid (AWOP) and the Capitation Rates development for the Program of All-inclusive Care for the Elderly (PACE) Contracts. The AWOP and PACE Capitation rates are periodically developed and submitted by a qualified actuary, either employed or retained by the Oregon Health Authority (OHA). The AWOP calculated for each PACE program are done in a manner that provides the best estimate of the per member per month cost of providing comparable acute medical and long-term care services to the PACE-eligible population in the PACE service area, if those eligible were not actually enrolled in PACE. PACE-eligible individuals, for the purposes of Medicaid, are persons living in a PACE service area who are age 55 years or older, meet the state's eligibility criteria for a nursing facility level of care with a service priority level (SPL) 1 - 13, and are Medicaid eligible (which excludes Medicare Savings Plan only individuals who are not Medicaid eligible, MAGI beneficiaries who are not receiving long-term services and supports, and individuals who are assessed for the first time with SPL 14 - 18).

Acute Care:

The methods, assumptions, and benefits considered in calculating the PACE acute care AWOPs are generally the same as those used to develop the Oregon Health Plan CCO capitation rates. The PACE methods also consider the mix of delivery systems used in the Oregon Health Plan (OHP), which includes capitated and non-capitated programs. These assumptions include trends, completion factors, and adjustments for data issues and programmatic changes. Where appropriate these assumptions are modified for the PACE-eligible population and contract period.

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Program of All-inclusive Care for the Elderly (PACE) Rate Methodology and Amount That Would Have Otherwise Been Paid (AWOP) Calculation (cont.)

Acute Care (Cont):

1. The appropriate Long Term Services and Supports (LTSS) eligible population excluding PACE enrollees and their acute costs are extracted from member databases and summarized by relevant factors, such as service category and service priority level. Appropriate adjustments are made for account for data completion. Supplemental data from outside the PACE service area may be used if needed to improve credibility of results. The eligibility member months by delivery system are used in the calculation of unadjusted acute per member per month amount.
2. Trend rates are developed and applied for various service categories, eligibility groups, and delivery systems.
3. Total projected costs per member per month are calculated for selected rate groups.

Long Term Care:

The Long-Term Care (LTC) component of the PACE AWOP is developed in a similar manner to the acute care AWOP. However, the LTC services for the PACE-eligible population are only paid on a fee-for service basis. Additionally, certain services appropriate for inclusion in the AWOP, but not included in the MMIS system, were identified and their costs were included in the calculation. These included client contributions paid directly by the individuals to providers, including payments to nursing homes, assisted living, residential care facilities, memory care and adult foster homes.

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Program of All-inclusive Care for the Elderly (PACE) Rate Methodology and Amount That Would Have Otherwise Been Paid (AWOP) Calculation (cont.)

The general process, by which the LTC AWOP was calculated, is as follows:

1. The appropriate LTSS eligible population, excluding PACE enrollees and their LTSS costs, are extracted from member databases and summarized by relevant factors, such as service category and service priority level. Appropriate adjustments are made to account for data completion. Supplemental data from outside the PACE service area may be used, if needed, to improve credibility of results. The LTSS eligibility member months are used in the calculation of unadjusted LTSS per member per month amount.
2. Trend rates are developed and applied for various service categories. For certain cost categories and time periods, scheduled changes to reimbursement levels are applied in lieu of trend.
3. Total projected LTSS costs per member per month are calculated for selected groups

Final Amount That Would Have Otherwise Been Paid (AWOP):

The per member per month costs reflect the expected acute plus LTSS claims costs per person per month, plus an administrative allowance. The Administrative allowance is calculated based on the cost of processing LTSS and acute claims for the comparable population, not PACE organization administrative costs. Since PACE enrollees can come from either fee-for-service or CCOs, costs are blended based on the distribution of PACE eligible member months between the delivery systems. Smoothing or credibility enhancement techniques, including development of rate cells, may be applied to mitigate the effects of small populations in certain cohorts. The rate cells for which an AWOP is calculated match the rate cells for which capitation payments are developed. AWOPs are then calculated from a blend of actual or projected PACE enrollment by rate cell. A percentage of the resulting AWOPs is used to calculate the PACE capitation rates. The PACE rates may vary by Medicare eligible status to account for the difference in cost due to Medicare coverage.

In addition to the prospective monthly capitation payment, the state may make a retrospective supplemental per member per month payment to a PACE organization if it meets specified performance measures for the reporting period. The State ensures the combined per member per month PACE capitation rate and the supplemental per member per month performance incentive payment will be less than the AWOP for each eligibility category.

TN No. 20-0001

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Supersedes TN 14-05

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1915(j) Self-Directed Personal Assistance Services

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

- A. In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.
- B. X In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver. ***Aging and Physically Disabled 1915(c) waiver #OR.0185.R05.01.**

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

- A. X State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

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1915(j) Self-Directed Personal Assistance Services

- B. Services included in the following Section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). Please list waiver names and services to be included.

iii. Payment Methodology

- A. X The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based wavier services.
- B. The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

- A. X The State elects to disburse cash prospectively to participants' self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- B. The State elects not to disburse cash prospectively to participants' self-directing personal assistance services.

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1915(j) Self-Directed Personal Assistance Services

iii. Voluntary Disenrollment

Please describe the safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional personal assistance services.

Participants may voluntarily disenroll from the IC program by communicating with their case manager. Individuals who voluntarily disenroll will have other service alternatives available to them, such as those services covered under the State plan. A voluntary disenrollment will not cause a reduction in participant's benefits that were determined based on their assessments and service plans. The case manager will be responsible for disenrolling the participant and will assist the participant in selecting other services and programs to serve their needs.

iv. Involuntary Disenrollment

- A. Please specify the circumstance under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional services.

Involuntary disenrollment will occur when a participant proves to be unable to self-direct purchase and payment of long-term support services, when a surrogate proves incapable of acting in the best interest of the participant, or when persons invalidate the terms of their Participation Agreement. They may be reinstated into another long-term supports option of their choice. Involuntary disenrollment may result from any of the following:

- A provider claim of non-payment of wages where the consumer or his/her representative cannot show proof of payment.
- Evidence that the Medicaid cash benefit was used for illegal purposes in accordance with local, state or federal statutes.
- Evidence that the Medicaid cash benefit cash benefit was used for purposes other than those that meet the individual's care needs.

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- Failure to comply with legal/financial obligations as an employer of domestic workers and/or unwillingness to participate in counseling and training to remedy lack of compliance.
 - Inability to manage the cash benefit as evidenced by:
 - Overdrafts of the consumer's Independent Choices bank account;
 - Non-compliance with recommendations for training or use of community resources; or
 - Failure to maintain health and well-being by obtaining adequate personal care as evidenced by:
 - Declines in physical functional status which are not attributable to changes in health status; or
 - Substantiated complaints of the consumer's self-neglect, neglect, or other abuse on the part of the consumer or surrogate.
- B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-direction and traditional service delivery models.

Disenrollment, for reasons other than Medicaid ineligibility, will not cause a reduction in participant's benefits that were determined based on their assessments and service plans. The case manager will be responsible for disenrolling the participant and will assist the participant in finding other programs that may better serve their needs through the State plan. The case manager will assist the participant in rectifying any of the problems listed in "A" above before taking steps to disenroll the participant from the program.

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1915(j) Self-Directed Personal Assistance Services

If the issues cannot be rectified, the case manager will issue to participants a formal notice prior to any action taken to disenroll them from the program, whether they opt to transition into State plan attendant care services or not. The notice will include information about the participant's rights to an administrative hearing if they disagree with the action and the right to continuing benefits under the 1915(j) until a final order is issued.

vii. Participant Living Arrangement

Please list any additional restrictions on participant living arrangements, other than homes or property owned, operated or controlled by a provider of services, not related by blood or marriage to the participant.

Consumers must demonstrate the ability to assess and plan for care by maintaining a stable living situation, defined as continuous tenancy at a given residence for the past three months. If health issues or a no-fault situation has prompted a move within the past three months, proof of any three consecutive months of tenancy during the past year is acceptable. The state may waive the three consecutive months of tenancy as a condition of eligibility for the IC program.

In the event a participant moves from their own home to a substitute home such as an assisted living facility, an adult foster home, a residential care facility or into a nursing home, he or she will be considered ineligible for the IC Program, disenrolled and transitioned to another program that may better meet his or her care needs.

The provider of services may be related by blood or marriage.

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1915(j) Self-Directed Personal Assistance Services

v. Geographic Limitations and Comparability

- A. The State elects to provide self-directed personal assistance services on a statewide basis.
- B. The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe: _____
- C. The State elects to provide self-directed personal assistance services to all eligible populations.
- D. The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Aged individuals and physically disabled individuals 18 years and older that are enrolled in the APD 1915(c) waiver (0185) for Aged and Physically Disabled individuals over 18 that meet nursing facility level of care.
- E. The State elects to provide self-directed personal assistance services to an unlimited number of participants.
- F. The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

vi. Assurances

- A. The State assures that there are traditional personal assistance services, comparable in amount, duration and scope, to self-directed personal assistance services.

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- B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.
- C. The State assures that an evaluation will be performed of participants' need for self-directed personal assistance services for individuals who meet the following requirements:
 - i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
 - ii. Are entitled to and are receiving home and community-based services under a Section 1915(c) waiver; or
 - iii. May require self-directed personal assistance services; or
 - iv. May be eligible for self-directed personal assistance services.
- D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a Section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

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- E. The State assures that a support system will be provided to individuals that meets the following:
- i. Appropriately assesses and counsels individuals prior to enrollment;
 - ii. Provides appropriate counseling, information, training and assistance to ensure that participants are able to manage their services and budgets;
 - iii. Offers additional counseling, information, training or assistance, including financial management services:
 1. At the request of the participant for any reason; or
 2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.
- F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.
- G. The State assures that an evaluation will be provided to CMS every three years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.
- H. The State assures that the provisions of Section 1902(a)(27) of the Social Security Act, and 42 CFR 431.107, governing provider agreements, are met. The State provides Criminal History Checks at no cost to participants for all providers. However, the participant maintains the ability to decide whether or not to employ the provider. As a program truly governed by self-direction, Independent Choices allows the participant to recruit, hire, train, and fire the provider of their choice.

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- I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

- J. The State assures that the methodology used to establish service budgets will meet the following criteria:
 - i. Objective and evidence based.
 - ii. Applied consistently to participants.
 - iii. Open for public inspection.
 - iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
 - v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
 - vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
 - vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.

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- viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
- ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

Please describe safeguards in place, when States permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Any changes to the service plan that include a change in the care setting must have the review of a case manager.

Entities or individuals that have responsibility to develop service plans do not provide other direct services to participants.

xi. Quality Assurance and Improvement Plan

Please describe the State's quality assurance and improvement plan, including

- i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
- ii. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

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Anyone may file a complaint with the Governor's Advocacy Office (GAO) in the Office of the Director of the Department of Human Services or with the local APD or AAA office. Local APD and AAA offices have the responsibility to resolve any complaints that are brought to them. In the event that the GAO receives the complaint they will enter it in a database and forward the complaint to the appropriate branch office or responsible program entity to initiate the resolution process. APD central office can access monthly reports on the types of complaints filed, the outcomes and whom the complaint involves.

There is no limitation on the types of complaints an individual may file. The majority of complaints are regarding client benefits or dissatisfaction with the case manager. The goal is to remedy complaints at the lowest level possible. After the local office receives a complaint from the consumer directly or via the GAO the remediation process begins. The process includes:

- Participant contacted by local program supervisor within a mandated time frame, at which time an in-person or telephone meeting is scheduled (participant may have a formal or informal support person/advocate present during the meetings);
- Fact finding and research is conducted by the local office prior to participant contact, during the meeting session, and following the meeting using a variety of sources and methods;
- Once the complaint is resolved satisfactorily, a letter of determination is sent to the participant (optional on a case-by-case basis), and the GAO and next-level manager are notified;
- If the complaint is not resolved, it is referred to next management level for review and follow-up.

If the complaint cannot be resolved at the local office and service area levels, a Central Office team will assume reexamination and continuance of complaint process.

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The participant may pursue grievance through the GAO or the appropriate federal program authority, including the court system.

The DHS CMS Waiver Review Unit reviews and monitors the accuracy and consistency of waiver operational and administrative functions performed by all local offices, including AAAs, through two ongoing processes:

a. In a two-year cycle, the CMS Waiver Review Unit conducts a field review, evaluating activities in all local DHS and AAA offices against State plan requirements such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, consumer satisfaction and cost effectiveness. The process of evaluation involves CMS Waiver Review Unit examination of a sample of participant cases through review of data stored in electronic databases, review of case files on-site, and individual interviews that include an assessment of consumer satisfaction. The CMS Waiver Review Unit records findings using a standardized tool and issues a formal finding in a report to the local office identifying trends in policy and rule application. The local office must submit a plan of correction to DHS within 30 days of receipt of this report that addresses any issues found in the CMS Waiver Review Unit report. DHS then issues a final report to the local office. DHS enters details of the review of each individual's record into the Quality Management Data Base (QMDB) for tracking. The CMS Waiver Review Unit revisits local offices to follow-up with the written corrective action plans to ensure compliance and remediation of any issues addressed in the final report.

The assessment methods used by the CMS Waiver Review Unit include file reviews, on-site reviews, interviews and assessments with individuals receiving services, and service plan reviews. Data is entered into a database.

1. These processes are a source of ongoing data about assistance with waiver enrollment, LOC activities, participant services plans, and prior authorization of waiver services.

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The process also provides information, through direct observation and review of factors associated with participant outcomes and satisfaction that aids evaluation of other functions such as dissemination of information concerning the waiver to potential enrollees, recruitment of providers, conduct of utilization management functions and training/technical assistance.

System performance indicators will be used to measure and track program activities and processes to assure that participant access, choice and satisfaction are achieved. Participant-centered outcome and satisfaction measures will be used to assure that service delivery meets the needs of the participant as determined in the Service Plan and are timely, efficient and effective, as directed by the participant.

The following performance and outcome measures will be used:

1. Participant enrollment processes are timely and accurate.
2. Participant-directed In-Home Services begin in a timely manner.
3. Overall costs for participant-directed services are comparable to or less than total costs for State plan HCBS clients living in their own homes.
4. Participants are given a choice of participant-directed or State plan HCBS services.
5. Participants have positive experiences with their care arrangements and service delivery.
6. The number of voluntary and involuntary program disenrollments is low.
7. The participant is able to address and reduce any unmet needs, with Case Manager assistance, if necessary.
8. Support for participants in delaying or avoiding admissions to nursing facilities is enhanced.
9. The Home Care Worker Registry can be utilized to support participant-directed service provisions.
10. Home Care Workers are subject to criminal history checks.
11. Home Care Workers provide services as agreed upon with and scheduled by the participant.

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12. Participants pay Home Care Workers accurately and in a timely manner.
13. Case Managers provide accurate and timely responses to participants to address their needs.
14. The proportion of abuse, neglect, misappropriation and exploitation, and protective services reports is low.
15. The Service Plans of participants have a health and safety risk assessment and strategies/protocols to address identified risks.

APD will continuously monitor the health and welfare of all participants receiving services through this option. One of the central activities to the whole APD service delivery system is the well-developed and consistent case management structure. Case managers assess for service needs, develop care plans, and authorize services. The assessment process includes a discussion and documentation of the participant's strengths, limitations and preferences.

APD will ensure that individuals receiving 1915(j) services are safe and secure in their homes, taking into account their informed and expressed choices by continuing to conduct on-site, random sample reviews by the CMS Waiver Review Unit at each APD and AAA office every two years. The review includes a home visit with the participant to verify the information from the participant's file.

APD has a variety of ongoing QA improvements to further ensure the health and welfare of participants. These projects include:

- An APD consumer satisfaction survey, conducted every 2 years, to assess satisfaction in self-directed services; beginning January 2008; and
- Distribution of an emergency preparedness handbook to all in-home service participants.

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APD maintains, and participates in, systems and procedures that promote financial accountability in all home and community-based services by conducting the following activities:

- Internal audits of various APD programs, including all in-home programs, by the DHS Internal Audit staff;
- External periodic audit activities by Oregon's Secretary of State staff.

vii. Risk Management

A. Please describe the risk assessment methods used to identify potential risks to participants.

Health risks. During initial plan of care development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. If the case manager identifies health or medication risks to a recipient living at home, he or she may refer a Registered Nurse under contract with APD to conduct a nursing assessment and may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule. Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards. The goals of community nursing care are to: maintain participants at functional level of wellness; minimize risk for participant; maximize the strengths of the participant and the care provider; and promote autonomy and self-management of health care through teaching and monitoring.

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Vulnerability for Abuse. During the assessment, the case manager may identify other risks and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be referred for protective services or guardianship services in the absence of legal representatives to assist with decision-making. Although not mandated, the State may request that a representative be selected in cases where the participant lacks the ability to make an informed decision. The participants have the right to choose their own representative. If the participant appears to be significant risk, the case manager may refer the case for protective services or guardianship service in the absence of legal representatives to assist with decision-making.

B. Please describe the tools or instruments used to mitigate identified risks.

During initial person-centered plan development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. (Relevant portion of CA/PS assessment available on request.) During the service planning process, the individual and/or their representatives discuss risk factors and back-up plans. The individual's plan of care is developed and information regarding risk and back-up plans is incorporated into the person-centered plan. There is a section in the CAPS tool that incorporates identified risks and back-up plans. This information is part of the assessment summary section of the service plan.

Case managers use a risk assessment and monitoring instrument, in conjunction with face-to-face CA/PS evaluations, to evaluate new participants and participants who have just experienced significant changes.

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The instrument will provide guidelines for contact frequency that are commensurate with the risk assessed.

The instrument will rank the level of risk on a 0-3 scale across ten client factors, with 0 being no risk, 1 = low risk, 2 = moderate risk, and 3 = high risk.

Client factors measured:

- 1) Physical functioning;
- 2) Mental and emotional functioning;
- 3) Cognitive functioning;
- 4) Behavioral issues;
- 5) Income/financial issues;
- 6) Safety/cleanliness of residence;
- 7) Service plan meets medical or physical needs;
- 8) Service plan meets mental, emotional, or behavioral needs;
- 9) Adequacy or availability of informal supports;
- 10) Access to needed care or services;
- 11) Power Outage
- 12) Natural Disaster/Extreme Weather

Case manager client contact frequency criteria:

- For clients assessed at high risk (level 3) in three or more factor areas, at least monthly.
- For clients assessed at high risk (level 3) in one or two factor areas, at least quarterly.
- For clients assessed at moderate, low, or no risk (levels 2, 1, or 0) in all factor areas, case managers would have discretion to determine the contact frequency, with at least one additional contact per year.

If the case manager identifies risks to a recipient living at home or in a foster home, he or she may refer a Registered Nurse under contract with DHS to conduct a nursing assessment and may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule.

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Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards. The goals of community nursing care are to: maintain participants at functional level of wellness; minimize risk for participant; maximize the strengths of the participant and the care provider; and promote autonomy and self-management of health care through teaching and monitoring. For recipients living in community-based care facilities, the case manager will work with the facility staff and the facility nurse to address health concerns.

The case manager may identify other risks and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be referred for protective services or guardianship services in the absence of legal representatives to assist with decision-making. Although not mandated, the State may request that a representative be selected in cases where the participant lacks the ability to make an informed decision. The participants have the right to choose their own representative. If the participant appears to be significant risk, the case manager may refer the case for protective services or guardianship service in the absence of legal representatives to assist with decision-making.

- C. Please describe how the State will ensure that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated.

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Program participants will be assessed at program implementation and semi-annually thereafter. The assessment process will identify the consumer's ability to perform activities of daily living, self-management tasks, and determine the consumer's ability to address health and safety concerns. The case manager will conduct this assessment in accordance with standards of practice established by the Department as described in OAR Chapter 411, Division 030.

During initial plan of care development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. (Relevant portion of CA/PS assessment available on request.)

The case manager may identify other risks associated with vulnerability to abuse and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Program participants must demonstrate and have recognized capability to appropriately direct and purchase his/her own in-home care. If the participant is unable to do so, they must have a family member, legal representative or other representative designated as surrogate who is willing and able to arrange and purchase supports on the consumer's behalf and to sign the Independent Choices Participation Agreement.

APD has alternate service providers such as Medicaid contracted in-home care agencies in some regions that an individual can employ on short notice if they cannot locate a Homecare Worker who meets their needs.

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- D. Please describe how the State will ensure that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance.

Local APD and AAA case managers have the responsibility for assessing the individual's level of care and developing a plan of care in accordance with the individual's choice of services to be provided. The case manager must address all of the met or unmet needs of the participant through the assessment and provide the participant with a copy of the service plan for signature by all parties for the authorized services. The case manager will consult with the participant every six months to reassess, review and verify the appropriate services are being offered and performed. All plans are developed with input from the participant, participant's representative and anyone else the participant requests.

The state may utilize the risk assessment and monitoring instrument by telehealth if:

- o The participant agrees to participate in this manner; and
- o The case manager will determine if An in-person evaluation is not considered necessary in order to properly assess or monitor.

xiii. Qualifications of Providers of Personal Assistance

- A. The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.
- B. The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

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viii. Use of a Representative

- A. The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.
- i. _____ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.
- B. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

ix. Permissible Purchases

- A. The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or decrease a participant's dependence on human assistance.
- B. _____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or decrease a participant's dependence on human assistance.

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Financial Management Services

- A. The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.
- i.* The State elects to provide financial management services directly, or use a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or
 - ii.* The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth in 45 CFR Section 74.40 – Section 74.48.)
 - iii.* The State elects to provide financial management services using “agency with choice” organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.
- B. The State elects to perform financial management services on behalf of participants’ self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

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1905(a)(29) Medication-Assisted Treatment (MAT)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

- a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).
- b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.
- c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

- a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT services are provided in accordance with a beneficiary's Individual Service and Support plan (ISSP). MAT OUD Rehabilitative treatment must be recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under state law.

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1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iii. Service Package (Cont)

Individual counseling therapy/Individual family and/or couple counseling provides individual counseling therapy in a private setting as identified by their ISSP. The duration/frequency of the treatment services are determined utilizing the ISSP and the individual's needs. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision.

Group counseling/ Group family and/or couple counseling therapy services provided is designed to assist in the attainment of goals described in the service plan. Goals of Individual, Group or Family level treatment may include enhancing interpersonal skills, mitigating the symptoms of OUDs, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for group therapy must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. Duration/frequency of this service is determined by the individual's needs and documented in their service plan. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their service plan. Group Family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision.

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1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iii. Service Package (Cont)

Peer Support services can be provided to individuals who are under the consultation, facilitation or supervision of a competent OUDs treatment professional who understands rehabilitation and recovery. Peer Support services promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills in order to facilitate the recovery of others with opioid use disorders. Peer services include self-help support groups by sharing the peer counselor's own life experiences related to SUDs and will build support mechanisms that enhance the consumers' recovery and restores their ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc.). Services provided by peer supports are described in the individualized ISSP which uses a person-centered planning process to promote participant ownership of the plan of care and delineates specific goals. Providers authorized to provide services are certified Peer Support Specialists under appropriate supervision.

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1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iii. Service Package (Cont)

Medication management is for the prescribing and/or administering and reviewing of medications and their side effects, including both pharmacological management as well as supports and training to the individual. This service shall be rendered by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or care coordination managers, but includes only minimal psychotherapy. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. Time spent with the enrollee is the only direct service billable component of this modality. Duration/frequency of this service is determined by the individual's needs and documented in their ISSP. Collection and handling of specimens for substance analysis are included in this service. Providers authorized to provide these services include LMP, QMHP, CADC, OTP and interns under appropriate supervision.

iii. Service Package (Cont)

- a. Please include each practitioner and provider entity that furnishes each service and component service.
 - A. Licensed Medical Practitioners (LMP);
 - B. Certified Alcohol and Drug Counselor (CADC);
 - C. Qualified Mental Health Professional (QMHP);
 - D. Peer-Support Specialist;
 - E. Pharmacist;
 - F. Intern.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

b) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

B. **Licensed Medical Practitioners (LMPs)** meets the following minimum qualifications:

3. Holds at least one of the following educational degrees and valid licensure:

- a. Physician licensed to practice in the State of Oregon;
- b. Advanced Practice Nurses including Clinical Nurse Specialist; and Certified Nurse Practitioner licensed to practice in the State of Oregon; or
- c. Physician's Assistant licensed to practice in the State of Oregon.

B. **"CADC" means a Certified Alcohol and Drug Counselor:**

1. CADC I; requires education, supervised experience hours and successful completion of a written examination. 150 hours of Opioid use disorder education provided by an accredited or approved body. 1,000 hours of Supervised Experience, Completion of the NCAC I professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors.

2. CADC II; a minimum of a BA/BS degree, with a minimum of 300 hours of Opioid use disorder education provided by an accredited or approved body. 4,000 hours of Supervised Experience, Completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors. Completion of the NAADAC Case Presentation Examination.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iii. Service Package (Cont)

3 CADC III; a Minimum of a master's degree with a minimum of 300 hours of Opioid use disorder education provided by an accredited or approved body. 6,000 hours of Supervised Experience, Completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors. Completion of the NAADAC Case Presentation Examination.

CADC are supervised by a Clinical supervisor in substance use disorders treatment programs who are certified or licensed by a LMP or QMHP. CADC must obtain a certificate of approval or license from the Division for the scope of services to be reimbursed.

C. "**QMHP**" must be licensed, or be employed by, or contract with, an organization that has obtained a certificate of approval from the Division for the scope of services to be reimbursed. QMHP is a Licensed Medical Practitioner or any other person meeting the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

1. Graduate degree in psychology;
2. Bachelor's degree in nursing and licensed by the State of Oregon;
3. Graduate degree in social work;
4. Graduate degree in a behavioral science field;
5. Graduate degree in a recreational, art, or music therapy; or
6. Bachelor's degree in occupational therapy and licensed by the state of Oregon;
7. Licensed by the Oregon state Board of Psychologist examiners, Licensed Social Workers, Licensed Professional Counselors and Therapists; and

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iii. Service Package (Cont)

8. Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi axial DSM diagnosis; write and supervise a treatment plan; conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of their training. Must also hold a Licensed or Certified in Alcohol and Drug Counseling.

D. **“Peer-Support” Specialist** means a person delivering services under the supervision of a QMHP who meets the following minimum qualifications as documented by the LMHA or designee:

1. An Individual who has successfully completed training through a curriculum approved by AMH.

This curriculum focuses on six (6) principles including:

- Being culturally appropriate
- Includes concepts of informed choice
- Creating partnerships
- Being person centered
- Utilize strengths-based care concepts
- Utilize trauma informed care concepts

Curriculum must contain the following specific elements, at a minimum:

- Communication skills and concepts
- Documentation skills and concepts
- Education specific to peer population and special needs of this population
- Knowledge of the recovery model and concepts of resiliency
- Ethics
- Knowing specific and applicable laws and regulations
- Knowing the related resources, advocacies and community support systems

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iii. Service Package (Cont)

And the individual:

1. Is a self-identified person currently or formerly receiving mental health services; or
2. Is a self-identified person in recovery from a opioid use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
3. Is a family member of an individual who is a current or former recipient of addictions or mental health services.

E. "**Pharmacist**" means an individual licensed by this state to engage in the practice of pharmacy or to engage in the practice of clinical pharmacy. Pharmacy means a place that meets the requirements of rules of the board, is licensed and approved by the board where the practice of pharmacy may lawfully occur and includes apothecaries, drug stores, dispensaries, hospital outpatient pharmacies, pharmacy departments and prescription laboratories but does not include a place used by a manufacturer or wholesaler.

F. "Intern" means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:

1. be currently enrolled in a graduate program, for at least a master's degree, for degrees for psychology, social work or in a Bachelor of Science field.
2. Has a collaborative educational agreement with the CMHP (provider) and the graduate program working within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider.
3. Receives, at the minimum, weekly supervision, by a qualified clinical supervisor, employed by the provider of services.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

iv. Utilization Controls (Cont)

The state has drug utilization controls in place. (Check each of the following that apply)

- Generic first policy
- Preferred drug lists
- Clinical criteria
- Quantity limits

The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Counseling and behavioral therapy:

There are no hard limitations, quantity and treatment duration is based on medical necessity and assessments and treatment plans.

MAT drugs and biologicals:

Supply limits, early refill thresholds and therapeutic duplication are enforced by Prior authorization (PA) and Quantity limits.

- Prior authorization is required for high-dose products to prevent inappropriate and off-label use.

If presented with a prescription of an opioid, a licensed pharmacist may provide counseling and prescribe naloxone with the necessary medical supplies to administer.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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1905(a)(29) Medication-Assisted Treatment (MAT) (Cont)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on 10/24/2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 68). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

Transmittal #91-25
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State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

The following services are provided.

For children (under age 21) and pregnant women all services described in Attachment 3.1-A, except 3.1-A 15.a and 15.b and 3.1-A 16.

*Description provided on Attachment

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TN No. 91-20 HCFA ID: 014OP/0102A

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AUGUST 1991

Transmittal #91-25
ATTACHMENT 3.1-B
Page 2
OMB No. 0938-

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind & Disabled

1. Inpatient hospital services other than those provided in an institution for mental diseases.
/ / Provided / / No limitation / / With limitations*
- 2.a. Outpatient hospital services.
/ / Provided / / No limitation / / With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan).
/ / Provided / / No limitation / / With limitations*
- c. See below
3. Other laboratory and X-ray services.
/ / Provided / / No limitation / / With limitations*
- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
/ / Provided / / No limitation / / With limitations*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
/ / Provided
- c. Family planning services and supplies for individuals of childbearing age.
/ / Provided / / No limitation / / With limitations*
- 2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
/ / Provided / / No limitation / / With limitations

*Description provided on Attachment.

TN No. 91-25 Approval Date 1/23/92 Effective Date 11/1/91
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APRIL 1992

Transmittal #92-16
ATTACHMENT 3.1-B
Page 2a

State/Territory: Oregon

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

/ / Provided / / No limitation / / With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

/ / Provided / / No limitation / / With limitations*

*Description provided on Attachment.

TN No. 92-16 Approval Date 8-12-92 Effective Date 4-1-92
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SEPTEMBER 1986

Transmittal #91-20
ATTACHMENT 3.1-B
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OMB No. 0938-0193

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' Services
// Provided // No limitation // With limitations*
 - b. Optometrists' Services
// Provided // No limitation // With limitations*
 - c. Chiropractors' Services
// Provided // No limitation // With limitations*
 - d. Other Practitioners' Services
// Provided // No limitation // With limitations*
7. Home health services
- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
// Provided // No limitation // With limitations*
 - b. Home health aide services provided by a home health agency.
// Provided // No limitation // With limitations*
 - c. Medical supplies, equipment, and appliances suitable for use in the home.
// Provided // No limitation // With limitations*
 - d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
// Provided // No limitation // With limitations*

*Description provided on Attachment.

TN No. 91-20 Approval Date 10/30/91 Effective Date 7/1/91
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SEPTEMBER 1986

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ATTACHMENT 3.1-B
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OMB No.: 0938-0193

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind & Disabled

8. Private duty nursing services.
// Provided // No limitation // With limitations*
9. Clinic services.
// Provided // No limitation // With limitations*
10. Dental services.
// Provided // No limitation // With limitations*
11. Physical therapy and related services.
- a. Physical therapy.
// Provided // No limitation // With limitations*
- b. Occupational therapy.
// Provided // No limitation // With limitations*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
// Provided // No limitation // With limitations*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
// Provided // No limitation // With limitations*
- b. Dentures.
// Provided // No limitation // With limitations*

*Description provided on attachment-

TN No. 03-04

Approval Date 03/11/03

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SEPTEMBER 1986

Transmittal #03-04
ATTACHMENT 3.1-B
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State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

- c. Prosthetic devices.
// Provided // No limitation // With limitations*
- d. Eyeglasses.
// Provided // No limitation // With limitations*
- 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
 - a. Diagnostic services.
// Provided // No limitation // With limitations*
 - b. Screening services.
// Provided // No limitation // With limitations*
 - c. Preventive services.
// Provided // No limitation // With limitations*
 - d. Rehabilitative services.
// Provided // No limitation // With limitations*
- 14. Services for individuals age 65 or older in institutions for mental diseases.
 - a. Inpatient hospital services.
// Provided // No limitation // With limitations*
 - b. Skilled nursing facility services.
// Provided // No limitation // With limitations*

*Description provided on Attachment.

TN No. 03-04

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September 1986

Transmittal #91-20
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OMB No. 0938-0193

State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

- c. Intermediate care facility services.
// Provided // No limitation // With limitations*
15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.
// Provided // No limitation // With limitations*
- b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.
// Provided // No limitation // With limitations*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
// Provided // No limitation // With limitations*
17. Nurse-midwife services.
// Provided // No limitation // With limitations*
18. Hospice care (in accordance with section 1905(o) of the Act.
// Provided // No limitation // With limitations*

*Description provided on attachment.

TN No. 91-20 - Approval Date 10/30/91 Effective Date 7/1/91

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TN No. 90-13 -

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ATTACHMENT 3.1-B
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State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): AGED, BLIND, DISABLED

19. Case management services and Tuberculosis related services
- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
- Provided: With limitations*
- Not provided.
- b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.
- Provided: With limitations*
- Not provided.
20. Extended services for pregnant women.
- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.
- Provided: + Additional coverage ++
- b. Services for any other medical conditions that may complicate pregnancy,
- Provided: + Additional coverage ++ Not provided.
21. Certified pediatric or family nurse practitioners' services.
- Provided: No limitations With limitations*
- Not provided.
- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this Attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment-

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Transmittal #03-04
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State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- Provided No limitations With limitations*
- Not Provided:
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
- Provided No limitations With limitations*
- Not Provided:
- b. Services provided in Religious Nonmedical Health Care Institutions..
- Provided No limitations With limitations*
- Not Provided:
- c. Reserved.
- d. Nursing facility services provided for patients under 21 years of age.
- Provided No limitations With limitations*
- Not Provided:
- e. Emergency hospital services.
- Provided No limitations With limitations*
- Not Provided:
- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
- Provided No limitations With limitations*
- Not Provided:

TN No. 03-04 Approval Date 03/11/03 Effective Date 02/01/03
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AUGUST 1990

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STATE OREGON

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89).

// Provided // No Limitations// // With Limitations*

*Description provided on Attachment.

TN No. 91-20 Approval Date 10/30/91 Effective Date 7/1/91
Supersedes
TN No. 90-26

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

-
25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home setting.

Provided: State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed

Limitations Described on Attachment

Not provided.

27. Program of Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

ATTACHMENT 3.1-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF OREGON

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

Standards and quality of care are assured by the medical community. All hospitals and skilled nursing facilities have utilization review processes. All medical and dental procedures must be provided by duly licensed and qualified practitioners.

TN# 759
Supersedes
TN# ---

Date Approved 4/10/74
Effective Date 1/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

METHODS OF ASSURING TRANSPORTATION

Non-Emergency Medical Transportation is provided as an optional medical service in accordance with 1902(a)(4)(A) of the Act and 42 CRF 431.53. NEMT is provided statewide under 1115 authority and in some cases under FFS State plan authority as outlined below.

Non-Emergency Medical Transportation under the 1115 waiver

Coordinated Care Organizations have NEMT included within their global budgets. CCOs may utilize Oregon's brokerage system to provide NEMT rides to eligible clients. The State provides NEMT services for eligible clients not enrolled in a CCO through Transportation brokers that service the state through approximately 8 regional brokerages. The brokers are required to have oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous. Brokerages are subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services. The brokers are governmental entities and can provide transportation itself or through subcontracts.

Brokers operate access management centers and interact with eligible Medicaid clients requesting access to eligible Medicaid services – trips are only authorized after brokers verify client eligibility and determine that clients do not have other transportation resources/options. Clients who have alternative means of no-cost transportation are not eligible for transportation through the brokerages. "No-cost" transportation includes rides provided by local social service agencies, law enforcement agencies, friends or relatives or any other means which would be considered by the Division to be a prior resource.

To directly save Medicaid medical funds (and as examples), brokers may authorize trips to Veterans' Hospitals, Shriners' Hospitals, and for services where Medicare and/or private insurance is primary and Medicaid coverage is secondary. Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

TN No. 13-07

Approval Date: 7/30/13

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Supersedes TN No. 12-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

METHODS OF ASSURING TRANSPORTATION (Cont)

Brokers assign trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities.

The NEMT broker provides transportation in accordance with Oregon Administrative Rules and under their Provider Agreement with the State to all mandatory and optional categorical populations included in section 2.2-A of this state plan. Populations excluded from NEMT under the 1115 waiver are Qualified Medicare Beneficiary (QMB only), Legalized aliens under 440.255 (CAWEM) and until January 1, 2014, the Medicaid expansion populations under the 1115 demonstration authority known as OHP Standard.

NEMT services provided include:

- wheelchair van
- non-emergent ambulance level transports (air & ground)
- taxi
- sedan transport
- stretcher car
- bus/train passes
- bus/train tickets
- secured transportation
- other transportation (described below)

When cost effective, appropriate, and necessary broker may use/authorize gas vouchers, grouped-ride vehicle, volunteers, parking, air transport and, client and necessary attendant reimbursements (mileage, lodging and meal reimbursement) as outlined at 42 CFR 440.170 (a) (3) (ii).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

METHODS OF ASSURING TRANSPORTATION (Cont)

Non-Emergency Medical Transportation outside of the 1115 waiver

Transportation services outside of the brokerage system are:

- Non-emergent ambulance level transports (except in area where provided by the broker)
- Client and necessary attendant reimbursement-includes mileage, meals & lodging (except in area where provided by the broker)
- Reimbursements for rides provided by volunteers

The State provides transportation (for cases outside of the brokerage system) to all mandatory and optional categorical populations included in section 2.2-A of this state plan. Populations excluded from NEMT under FFS are Qualified Medicare Beneficiary (QMB only), legalized aliens under 440.255 (CAWEM) and until January 1, 2014, Medicaid expansion populations under the 1115 demonstration authority known as OHP Standard.

NEMT payments outside of the 1115 brokerage are paid on a FFS basis as outlined in Attachment 4.19-B. The fee schedule is published on the Divisions web at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

Transportation is provided as an administrative activity in accordance with 1902(a)(4)(A) of the Act and 42 CFR 431.53 when payments are made directly to individuals as reimbursement for mileage or transportation related services.

All clients, regardless if served by the brokerage or the State, have the right to request a fair hearing and an appeal to a hearing decision, except in relation to provisions that are inapplicable under 42 CFR 440.170. Fair hearings are conducted before an impartial administrative law judge in accordance with the state's administrative hearings procedures (the same process as for other Medicaid healthcare services).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

METHODS OF ASSURING TRANSPORTATION (Cont)

The state/territory assures that it meets the minimum requirements for NEMT providers in section 1902(a)(87) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

General Coverage standards:

Transplant services, including inpatient and outpatient pre-and post-operative medical, surgical hospital, and related transportation services are covered for eligible beneficiaries when medically necessary.

The following standards apply to all transplant services:

- a. The recipient must be enrolled in the Oregon Health Plan at the time the service is provided and must have the OHP Plus (full Medicaid) benefit Package;
- b. Services are reasonable in amount, duration, and scope to achieve their purpose;
- c. Similarly situated individuals are treated alike;
- d. Provided in a Medicare approved transplant center and be an enrolled provider with Oregon's Medical Assistance Program;
- e. Transplants must be medically necessary and meet the requirements for physician and hospital services. No payment is made for any transplant not specifically listed below, except for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of Medicaid eligible children under the age of 21, for whom services are furnished based on medical necessity.

The following types of transplants and transplant-related procedures are covered under Oregon's Medical Assistance program subject to the standards and criteria determined by the Health Evidence Review Commission (HERC) Prioritized List of Health Services guideline notes:

- (a) Bone Marrow;
- (b) Cord blood;
- (c) Cornea;
- (d) Heart or combination Heart-Lung;
- (e) Intestine;
- (f) Kidney;
- (g) Liver or combination Liver-Kidney;
- (h) Lung single or bilateral
- (i) Pancreas or combination Pancreas- Kidney;
- (j) Peripheral Stem Cell, Autologous and Allogeneic,
- (k) Any other transplants the Health Evidence Review Commission (HERC) determine are to be added to the HERC Prioritized List of Health Services guideline notes.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

When services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers unless any of the conditions at 42 CFR 431.52(b) are met and all other criteria for a transplant are met.

Out-of-state centers will be considered if one of the following criteria exists:

- (1) The type of transplant required is not available in the state of Oregon and/or the type of transplant (e.g., liver transplant) is available in the state of Oregon but the Oregon transplant center does not provide that type of transplant for all clients or all covered diagnoses, (e.g., pediatric transplants);
- (2) An in-state transplant center requests the out-of-state transplant referral;
- (3) A contiguous out-of-state transplant center has a contract or special agreement with Oregon;
- (4) It would be cost effective as determined by OHA. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant center.

Donor services:

Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to the surgery.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Non-Covered Transplant Services:

The following types of transplants are not covered by the Oregon Medical Assistance program:

- a) Any transplants not listed in this state plan;
- b) Transplants that are considered experimental or investigational, or which are performed on an experimental or investigational basis, as determined by the Health Evidence Review Commission (HERC) and/or Oregon's Medical Assistance program.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation(s)

- | | |
|---|---|
| <p>1932(a)(1)(A)</p> | <p>A. <u>Section 1932(a)(1)(A) of the Social Security Act</u></p> <p>The State of Oregon enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).</p> <p>This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).</p> <p>Where the state’s assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future.</p> |
| <p>1932(a)(1)(B)(i)
 1932(a)(1)(B)(ii)
 42 CFR 438.2
 42 CFR 438.6
 42 CFR 438.50(b)(1)-(2)</p> | <p>B. <u>Managed Care Delivery System</u></p> <p>The State will contract with the entity(ies) below and reimburse them as noted under each entity type.</p> |

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- MCO
 - a. Capitation
 - b. The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

- 1. PCCM (individual practitioners)
 - a. Case management fee
 - b. Other (please explain below)

- 2. PCCM entity
 - a. Case management fee
 - b. Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
 - c. Other (please explain below)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- Provision of intensive telephonic case management
- Provision of face-to-face case management
- Operation of a nurse triage advice line
- Development of enrollee care plans.
- Execution of contracts with fee-for-service (FFS) providers in the FFS program
- Oversight responsibilities for the activities of FFS providers in the FFS program
- Provision of payments to FFS providers on behalf of the State.
- Provision of enrollee outreach and education activities.
 - Operation of a customer service call center.
 - Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.

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- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- Coordination with behavioral health systems/providers.
- Coordination with long-term services and supports systems/providers.
- Other (please describe): Conduct outcome measurement and provide outcome reports to the state.

42 CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.

In accordance with Public Law 111-5 and the Oregon Health Authority's Tribal Consultation and Urban Confer Policy, the Oregon Health Authority has collaborated and discussed with urban Indian health programs via thirty (30) meetings over two years on this state plan amendment. The nine Federally-recognized Tribes and Urban Indian Health Program have requested this program and state plan amendment, and this request is the culmination of nearly two years of effort on the part of the state to fulfill this request. Tribes have been partners with the state in developing and planning for this model. In addition to these thirty meetings, the tribes and Oregon discuss the IMCE program at our monthly Tribal Technical Advisory Board meetings as required by our Medicaid waiver. Tribal consultation and urban confer on this state plan amendment was initiated formally through the Dear Tribal Leader Letter that was distributed on 12/28/20 and a face-to-face meeting on 1/29/21.

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Citation(s)

C. Public Process (Cont)

The Oregon Health Authority, the nine Federally-recognized Tribes, and the Urban Indian Health Program will continue to discuss the IMCE program at monthly meetings held between the tribes and the state, as well as during ongoing technical assistance meetings regarding IMCE program and policy. Any additional developments in IMCE program operations or policy will be addressed in a collaborative and consultative manner, as required by the Oregon Health Authority’s Tribal Consultation and Urban Confer Policy. IMCE policy developments reflected in Oregon Administrative Rules will be open to public involvement via the state’s administrative rulemaking process, which provides public notice of opportunities to provide input on rulemaking via the rules advisory committee process.

D. State Assurances and Compliance with the Statute and Regulations.
 If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

- | | | |
|---|----|--|
| 1932(a)(1)(A)(i)(I) | 1. | <input type="checkbox"/> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met. |
| 1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A) | 2. | <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section of the Act for PCCMs and PCCM contracts will be met. |
| 1932(a)(1)(A)
42 CFR 438.50(c)(3) | 3. | <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met. |
| 1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C) | 4. | <input checked="" type="checkbox"/> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met. |

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Citation(s)

- | | | |
|---|-----|---|
| 42 CFR 438.10(g)(2)(vii)
1932(a)(1)(A)5. | 6. | <input checked="" type="checkbox"/> The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i). |
| 1932(a)(1)(A)
of
42 CFR 438
1903(m) | 6. | <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities met. |
| 1932(a)(1)(A)
42 CFR 438.4
42 CFR 438.5
42 CFR 438.7
42 CFR 438.8
42 CFR 438.74
42 CFR 438.50(c)(6) | 7. | <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met. |
| 1932(a)(1)(A)
CFR 447.362
42 CFR 438.50(c)(6) | 8. | <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 42 447.362 for payments under any non-risk contracts will be met. |
| 45 CFR 75.326 | 9. | <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met. |
| 42 CFR 438.66 | 10. | Assurances regarding state monitoring requirements:
<input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.
<input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.
<input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met. |

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Citation(s)

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area.

1. Included Populations. Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E)**, and the geographic scope of enrollment.

Under the **Geographic Area** column, please indicate whether the nature of the population’s enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column.

Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

2. Voluntary Only or Excluded Populations. Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

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Citation(s)

Voluntary Only or Excluded Populations (Cont)

Eligibility Group	Citation	M	V	E	Geographic Area	Notes
Indian and/or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).	25 USC 1603(13) 1603(28) 1679(a) 42 CFR 136.12; 42 CFR 438.14(a).		X		State-wide	

3. (Optional) Other Exceptions. The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Eligibility Group	V	E	Notes
Other Insurance --Medicaid beneficiaries who have other health insurance			
Reside in Nursing Facility or ICF/IID --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities		X	
Reside in Nursing Facility or ICF/IID --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities			

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Citation(s)

1932(a)(4)

42 CFR 438.54 F.

Enrollment Process

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))

- a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

IMCEs will have the option of two enrollment methods:

IMCEs can submit to the state a monthly roster of members enrolled into IMCE, indicating new and terminated enrollments. The state will validate member eligibility for IMCE enrollment.

IMCEs can, on a monthly basis, receive and validate a list generated by the state of all eligible AI/AN members residing within the IMCE's service area.

New enrollments shall take effect the month after their inclusion on a monthly roster. After validating eligibility for the IMCE program, the state shall notify the AI/AN member of their IMCE enrollment. The standard welcome notice will provide members with the name, location, and contact information of their IMCE, along with all the information required under 42 CFR 438.10(c)(4), 42 CFR 438.10(e), and 42 CFR 438.54(c)(3). The notice will explain that IMCE enrollment is voluntary, and that members can choose to disenroll at any time by requesting disenrollment from their IMCE. Members will be reminded of this disenrollment right when they receive their welcome package from the IMCE as part of the enrollment process.

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Citation(s)

State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

1. For **voluntary** enrollment (Cont)

- b. If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

i. Please indicate the length of the enrollment

- c. If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
- i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

IMCEs may limit enrollment to American Indian/Alaska Native individuals who:

- Are enrolled in, or eligible for, the Oregon Health Plan;
- Reside within an IMCE's service area; and
- Do not reside in a nursing facility or intermediate care facility for individuals with intellectual disabilities

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Citation(s)

As described above, IMCEs will either submit a monthly roster of members to be enrolled into their IMCE, for validation by the state; or will receive from the state a monthly roster of eligible patients, to be validated by the IMCE. This process ensures that IMCEs can limit enrollment as allowed in §1932(h)(3) of the Social Security Act.

After the state has verified that a member is eligible, the state will send the member an enrollment notification that includes all required information, including a notification of the member’s right to disenroll. Member enrollment will take effect the month after inclusion on the monthly roster, unless a member opts out of IMCE enrollment. As part of the enrollment process, members will receive a welcome notice from the IMCE that reminds them of their right to disenroll at any time.

The PCCM program will not limit members’ choice of provider, and so IMCE enrollment does not present any risk of disruption to existing provider-beneficiary relationships or relationships with providers that have traditionally served Medicaid beneficiaries.

- ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:
Enrollees will be permitted to disenroll at any time and these changes will take effect the 1st of the month after notification is communicated from the IMCE to the state.

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Citation(s)

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

b. If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.

i. Please indicate the length of the enrollment choice period: _____

c. If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

d. If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

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Citation(s)

1932(a)(4)
42 CFR 438.54

- 3. State assurances on the enrollment process.
Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

- a. The state assures that, per the choice requirements in 42 CFR 438.52:

- i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
- ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
- iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

- b. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

This provision is not applicable to this 1932 State Plan Amendment.

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Citation(s)

42 CFR 438.56(g) c. The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71 d. The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4) G. Disenrollment
42 CFR 438.56 1. The state will / will not limit disenrollment for managed care.
2. The disenrollment limitation will apply for N/A (up to 12 months).
3. The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

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Citation(s)

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*

As described above, the state will distribute standard welcome notices for new IMCE members. These notices will notify members of their right to disenroll from the IMCE at any time. Members will be reminded of this disenrollment right when they receive their welcome package from the IMCE as part of the enrollment process.

5. Describe any additional circumstances of “cause” for disenrollment (if any).

Individuals will be able to disenroll without cause by contacting their IMCE.

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Citation(s)

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
 42 CFR 438.50
 42 CFR 438.10

The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
 1903(m)
 1905(t)(3)

I. List all benefits for which the MCO is responsible.

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state’s Medicaid State Plan. For “other practitioner services”, list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #

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Citation(s)

1932(a)(5)(D)(b)(4)
 CFR 438.228

J. The state assures that each MCO has established an 42 internal grievance and appeal system for enrollees.

1932(a)(5)(D)(b)(5)
 42 CFR 438.62
 42 CFR 438.68
 42 CFR 438.206
 42 CFR 438.207
 42 CFR 438.208

K. Services, including capacity, network adequacy, coordination, and continuity.
 The state assures that all applicable requirements of 42. CFR 438.62, regarding continued service to enrollees, will be met.

The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.

The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.

The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.

The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.

1932(c)(1)(A)
 42 CFR 438.330
 42 CFR 438.340

L. The state assures that all applicable requirements of 42 CFR 42 438.330 and 438.340 regarding a quality assessment and performance improvement program and State quality strategy will be met.

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Citation(s)

1932(c)(2)(A) M. The state assures that all applicable requirements of
 42 CFR 438.350 42 CFR 438.350, 438.354 and 438.364 regarding an annual
 42 CFR 438.354 external independent review conducted by a qualified
 42 CFR 438.364 independent entity, will be met.

1932(A)(1)(a)(II) N. Selective Contracting Under a 1932 State Plan Option.

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will / will not intentionally limit the number of entities it contracts under a 1932 state plan option.

2. The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.
(Example: a limited number of providers and/or enrollees.)

The state will only contract with Indian Managed Care Entities that are Indian Health Service, Tribal 638, or Urban Indian Health Programs.

4. The selective contracting provision in not applicable to this state plan

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HEALTH HOMES FOR INDIVIDUALS WITH CHRONIC CONDITIONS
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES: CATEGORICALLY NEEDY

Reserved for future use

TN No. 14-09

Approval Date: 12/16/14

Effective Date: 7/1/14

Supersedes TN No. 11-11

§1915(i) State plan HCBS
 State/Territory: Oregon

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. (Specify the state’s service title(s) for the HCBS defined under “Services” and listed in Attachment 4.19-B):

Community-Based Integrated Supports (CBIS), HCBS Residential Habilitation, HCBS psychosocial Rehabilitation for persons with CMI, HCBS In-home Personal Care, Community Transportation, Home-Delivered Meals, Housing Support Services, Transition Services, and Pest Eradication Services.

2. Concurrent Operation with Other Programs. (Indicate whether this benefit will operate concurrently with another Medicaid authority): **Select one:**

<input type="radio"/>	Not applicable
<input checked="" type="radio"/>	Applicable
Check the applicable authority or authorities:	
<input type="checkbox"/>	<p>Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i></p> <p>(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);</p> <p>(b) the geographic areas served by these plans;</p> <p>(c) the specific 1915(i) State plan HCBS furnished by these plans;</p> <p>(d) how payments are made to the health plans; and</p> <p>(e) whether the 1915(a) contract has been submitted or previously approved</p>
<input type="checkbox"/>	<p>Waiver(s) authorized under §1915(b) of the Act.</p> <p><i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i></p>

§1915(i) State plan HCBS
State/Territory: Oregon

<input type="checkbox"/>	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
	<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
	<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
	<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>		
	<input checked="" type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i> Oregon Health Plan		

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (*Select one*):

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (<i>select one</i>):	
●	The Medical Assistance Unit (<i>name of unit</i>):	Health Systems Division
○	Another division/unit within the SMA that is separate from the Medical Assistance Unit (<i>name of division/unit</i>) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
○	The State plan HCBS benefit is operated by (<i>name of agency</i>) a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

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4. Distribution of State plan HCBS Operational and Administrative Functions.

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies): (Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Other State Operating Agency is the Oregon Department of Human Services, Aging and People with Disabilities Division who determine non- MAGI Medicaid eligibility as a part of its operational function.

Contracted Entity is an Independent and Qualified Agent (IQA) reviews participant service plans, prior authorizes HCBS services, conducts medical appropriateness review (utilization management) and quality assurance and quality improvement activities. The IQA also performs need based assessment, performs transition management and planning for individuals moving between home and community-based settings.

(By checking the following boxes the State assures that):

5. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

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- 6. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
- 7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
- 8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/22	12/31/22	2323
Year 2	1/1/23	12/31/23	2556
Year 3	1/1/24	12/31/24	2811
Year 4	1/1/25	12/31/25	3092
Year 5	1/1/26	12/31/26	3401

- 2. **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

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Financial Eligibility

1. **Medicaid Eligible.** . (By checking this box the state assures that): Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State’s Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)
2. **Medically Needy.** (Select one):

<input checked="" type="checkbox"/> The State does not provide State plan HCBS to the medically needy.
<input type="checkbox"/> The State provides State plan HCBS to the medically needy. (Select one):
<input type="checkbox"/> The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, medically needy individuals receive only 1915(i) services.
<input type="checkbox"/> The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (Select one):

<input checked="" type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By Other (specify State agency or entity with contract with the State Medicaid agency):

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Evaluation/Reevaluation of Eligibility

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications)*

Needs based evaluations are conducted by staff who meet the requirements of a Qualified Mental Health Professional.

Qualifications for a **QMHP** are:

- Graduate degree in psychology;
 - Bachelor's degree in nursing and be licensed by the State of Oregon. Nurses are accountable to abide by the Oregon Nurse Practice Act to determine if job descriptions are compliant with the competencies listed above;
 - Graduate degree in social work;
 - Graduate degree in a behavioral science field;
 - Graduate degree in recreational, art, or music therapy; OR
 - Bachelor's degree in occupational therapy and be licensed by the State of Oregon;
- AND

Education and experience which demonstrates the competencies to review the outcomes of an assessment including identify precipitating events, to include health and safety to self or others; gather histories of mental and physical disabilities, substance use, past mental health services and criminal justice contacts; assess family, cultural, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; develop a safety plan; and provide individual, family, and/or group therapy within the scope of their training.

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- 3. Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The IQA receives requests for eligibility determinations for individuals who are potentially eligible for 1915(i) HCBS services from a referrer.

IQA conducts an in-person assessment/reassessment with the individual, the individuals authorized or legal representative or guardian, if applicable, and in consultation with any other persons identified by the individual, such as, but not limited to, the spouses, family, friends, providers, and treating and consulting health and support professionals responsible for the individuals care to determine if an individual is eligible for 1915(i) HCBS services based on the diagnostic and needs-based criteria.

The tools utilized identify the individual's service and support needs are the Level of Care Utilization System (LOCUS) and the Level of Service Inquiry (LSI). Completion of these tools, along with the IQA's review and consideration of all pertinent and necessary information, and consultation with the parties identified above result in the IQA's development of the individual's person-centered service plan.

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3. Process for Performing Evaluation/Reevaluation. (Cont)

The IQA provides necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered and accommodated.

Reassessments, using the methodology described above, are conducted no less frequently than annually, when the individual requests a reassessment, or when the individual's needs have significantly changed.

OHA conducts eligibility evaluations/re-evaluations. The process is that the IQA conducts the assessment, OHA staff conducts the needs-based evaluation using information from the IQA assessment and determines eligibility. The outcome of the needs-based evaluation is input into MMIS. MMIS generates the notice to the individual, OHA informs the IQA of eligibility and then IQA follows up with person-centered planning process for eligible individuals.

4. **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.
5. **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors:
(Specify the needs-based criteria):

The individual has a need for assistance in two areas of Instrumental Activities of Daily Living (IADL) due to the symptoms of a behavioral health condition. IADLs include, but are not limited to, housekeeping including laundry, shopping, transportation, medication management, and meal preparation. Assistance is defined as hands-on, supervision, and/or cueing.

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6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>The person has a need for assistance in two areas of Instrumental Activities of Daily Living (IADL) due to the symptoms of a behavioral health condition. IADLs include, but are not limited to, housekeeping including laundry, shopping, transportation, medication management, and meal preparation. Assistance is defined as hands-on, supervision, and/or cueing.</p>	<p>For adults served under the Aging and Physical Disabilities Waiver, which requires NF LOC, be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010: (1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition. (2) Requires Full Assistance in Mobility, Eating, and Cognition. (3) Requires Full Assistance in Mobility, or Cognition, or Eating. (4) Requires Full Assistance in Elimination (5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.</p>	<p>1. The individual has a history of an intellectual disability or a developmental disability as defined below: "Developmental disability" means a disability that originates in childhood, that is likely to continue and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional. Developmental Disabilities include intellectual disability, autism, cerebral palsy, epilepsy, or other neurological disabling condition that require training or support similar to that required by individuals with mental retardation, <u>and</u> the disability:</p>	<p>Criteria for Long Term Psychiatric Inpatient Care</p> <ul style="list-style-type: none"> • Primary DSM Diagnosis is severe psychiatric disorder; • Documented need for 24-hour hospital level medical supervision; and • At least one of the following conditions are met: <ul style="list-style-type: none"> ○ A need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications. ○ Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days).

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Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
	<p>(6) Requires Substantial Assistance with Mobility and Assistance with Eating.</p> <p>(7) Requires Substantial Assistance with Mobility and Assistance with Elimination.</p> <p>(8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.</p> <p>(9) Requires Assistance with Eating and Elimination.</p> <p>(10) Requires Substantial Assistance with Mobility.</p> <p>(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.</p> <p>(12) Requires Minimal Assistance with Mobility and Assistance with Eating.</p> <p>(13) Requires Assistance with Elimination.</p>	<ul style="list-style-type: none"> • Originates before the individual attains the age of 22 years, except that in the case of intellectual disability, the condition must be manifested before the age of 18; and Originates in and directly effects the brain and has continued, or can be expected to continue, indefinitely; and • Constitutes a significant impairment in adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080; and • The condition or impairment must not be primarily attributed to mental or emotional disorders, sensory impairments, substance abuse, personality disorder, 	<ul style="list-style-type: none"> ○ Inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record. ○ Continued actual danger to self, others or property that is manifested by at least one of the following: <ul style="list-style-type: none"> ▪ The OHP Member has continued to make suicide attempts or substantial (life-threatening) suicidal gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats. ▪ The OHP Member has continued to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.

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Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		<p>learning disability or Attention Deficit Hyperactivity Disorder (ADHD). OAR 411-320-0020 or;</p> <ul style="list-style-type: none"> • Constitutes a "Intellectual Disability" significantly sub-average general intellectual functioning defined as full scale intelligence quotients (IQs) 70 and under as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior directly related to an intellectual disability as described in OAR 411-320-0080 that is manifested during the developmental period prior to 18 years of age. Individuals with a valid full-scale IQ of 71-75 may be 	<ul style="list-style-type: none"> ▪ The OHP Member has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment. <ul style="list-style-type: none"> ▪ Failure of intensive extended care services evidenced by documentation in the Clinical Record of: <ul style="list-style-type: none"> ➢ An intensification of symptoms and/or behavior management problems beyond the capacity of the extended care service to manage within its programs; and ➢ Multiple attempts to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit. <ul style="list-style-type: none"> ➢ Has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

*Long Term Care/Chronic Care Hospital

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Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		<p>considered to have an intellectual disability if there is also significant impairment in adaptive behavior as diagnosed and measured by a licensed clinical or school psychologist as described in OAR 411-320-0080. AND</p> <p>2. The individual has a significant impairment in one or more areas of adaptive behavior as defined in OAR 411-320-0020(3):</p> <p>(3) Adaptive Behavior" means the degree to which an individual meets the</p> <p>standards of personal independence and social responsibility expected for age and culture group. Other terms used to describe adaptive behavior include, but are not limited to, adaptive impairment, ability to function, daily living skills, and adaptive functioning.</p>	.

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Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		<p>Adaptive behaviors are everyday living skills including, but not limited to, walking (mobility), talking (communication), getting dressed or toileting (self-care), going to school or work (community use), and making choices (self-direction).</p> <p>e) "Significant impairment" in adaptive behavior means: (A) A composite score of at least two standard deviations below the norm; (B) Two or more domain scores as identified in subsection (b) of this section are at least two standard deviations below the norm; or (C) Two or more skilled areas as identified in subsection (d) of this section are at least two standard deviations below the norm.</p>	

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7. **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Persons who are twenty-one years of age or older with a chronic mental illness.

Pursuant to ORS 426.495 and Oregon Administrative Rule 309-019-0225, a person with a chronic mental illness means an individual who is diagnosed by a psychiatrist, a licensed clinical psychologist, a licensed independent practitioner as defined in ORS 426.005 or a nonmedical examiner certified by the Oregon Health Authority or the Oregon Department of Human Services as having chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder other than those caused by substance abuse.

- Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (*Specify the phase-in plan*):

8. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

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9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	<p>Minimum number of services.</p> <p>The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:</p> <div style="border: 1px solid black; width: 100px; text-align: center; margin: 5px 0;">1</div>
ii.	<p>Frequency of services. The state requires (select one):</p> <p><input checked="" type="radio"/> The provision of 1915(i) services at least monthly</p> <p><input type="radio"/> Monthly monitoring of the individual when services are furnished on a less than monthly basis</p> <p>If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:</p>

Home and Community-Based Settings

(By checking the following box the State assures that):

1. **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

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The state assures that this amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Provision of CBIS and HCBS Psychosocial Rehabilitation for persons w. CMI, is allowed for eligible individuals who are being temporarily served in an acute care hospital setting in order to enable direct care workers or other home and community-based providers to accompany individuals to acute care hospital setting in accordance with Section 3715 of the CARES Act.

- a) These services will be focused on providing personal, behavioral and communication supports not otherwise provided in an acute care hospital;
- b) The service will only be delivered in the acute care hospital setting for up to 30 days;
- c) The HCBS will be identified in an individual's person-centered service plan ;
- d) Provided to meet needs of the individual that are not met through the provision of hospital services;
- e) Not a substitute for services that the hospital is obligated to provide; and
- f) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

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- 4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Staff of the IQA who are Qualified Mental Health Professional (QMHP), conduct in-person assessments of support needs and capabilities of individuals residing in their own home or a community-based setting.

Qualifications for a QMHP are:

Graduate degree in psychology;

Bachelor's degree in nursing and be licensed by the State of Oregon. Nurses are accountable to abide by the Oregon Nurse Practice Act to determine if job descriptions are compliant with the competencies listed above;

Graduate degree in social work;

Graduate degree in a behavioral science field;

Graduate degree in recreational, art, or music therapy; or

Bachelor's degree in occupational therapy and be licensed by the State of Oregon;

AND

Education and experience which demonstrates the competencies to conduct an assessment including identify precipitating events, to include health and safety to self or others; gather histories of mental and physical disabilities, substance use, past mental health services and criminal justice contacts; assess family, cultural, social and work relationships; conduct a mental status examination; complete a DSM diagnosis; develop a safety plan; write and supervise the implementation of a person-centered treatment plan; and provide individual, family, and/or group therapy within the scope of their training.

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- 5. Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Staff of the IQA who are Qualified Mental Health Professional (QMHP) develop the person-centered service plans (PCSP). The IQA contractor is not authorized to provide 1915(i) HCBS.

Qualifications for a QMHP are:

- Graduate degree in psychology;
- Bachelor's degree in nursing and be licensed by the State of Oregon. Nurses are accountable to abide by the Oregon Nurse Practice Act to determine if job descriptions are compliant with the competencies listed above;
- Graduate degree in social work;
- Graduate degree in a behavioral science field;
- Graduate degree in recreational, art, or music therapy; OR
- Bachelor's degree in occupational therapy and be licensed by the State of Oregon;

AND

Education and experience which demonstrates the competencies to conduct an assessment including identify precipitating events, to include health and safety to self or others; gather histories of mental and physical disabilities, substance use, past mental health services and criminal justice contacts; assess family, cultural, social and work relationships; conduct a mental status examination; complete a DSM diagnosis; develop a safety plan; write and supervise the implementation of a person-centered treatment plan, and provide individual, family, and/or group therapy within the scope of practice.

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- 6. Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The IQA case manager works with the individual and/or their guardian or authorized legal representative, as applicable, to establish a time to engage with the individual in their residence or a location of their choosing, including via telehealth/telemedicine in accordance with HIPAA. When establishing an initial meeting, the IQA case manager will inform the individual of their choice to include others that may have information about their needs or people that are important to them or who are a support to them.

During the initial interaction or engagement with the individual, the IQA case manager provides information to the individual (and/or those people chosen by the individual) regarding service eligibility and any necessary referral processes, and services and supports covered under the 1915(i) HCBS State Plan or other eligible services. The IQA case manager provides education, instruction and information about the following:

- The needs assessment and the person-centered planning process, and how they are conducted;
- The range and scope of individual choices and options;
- The process for changing the person-centered service plan;
- The grievance and appeals process;
- The individual's rights, including federal and state HCBS rights:

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Supporting the Participant in Development of Person-Centered Service (Cont)

- The risks and responsibilities of self-direction;
- Free choice of providers and service delivery models;
- Reassessment and review schedules;
- Defining goals, needs and preferences;
- Identifying and accessing services, supports and resources; Development of risk management agreements; and
- Recognizing and reporting critical events, including abuse allegations.
- These supports are provided orally and in writing in a manner and language easily understood by the individual and others the individual has chosen to participate in the person-centered assessment and planning process. The IQA has developed print and online information about home and community-based services and supports, including information about available providers, services and the processes to referral and access to HCBS covered services and providers.

Assessment of an individual's support needs and capabilities may be completed by communication methods such as telehealth/telemedicine, in lieu of in-person visits, and in accordance with HIPAA, as directed by OHA.

To comply with 42 CFR 441.725(b)(9), appropriate IQA staff may obtain the individual's oral approval and document this approval in the case records as directed by OHA. The use of e-signatures that meet privacy and security requirements will be added as a method for the participant, legal representative, or guardian signing the PCSP to indicate approval of the plan. Oral consent is only used as authorization for providers to deliver services while awaiting receipt of the signed PCSP. Oral consent does not substitute for electronic or hardcopy signatures on the PCSPs.

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- 7. Informed Choice of providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The counties, or other case management entities, are involved in assisting participants in obtaining info and selecting 1915(i) providers, which options and choice are documented by the IQA on the PCSP with an attestation from the participant that they did have choice in providers.

- 8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

OHA will review a representative sample of person-centered service plans completed by the IQA using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.

OHA will review the IQA PCSPs using the standards for person-centered planning contained in the IQA contract.

(1) Contractor shall develop a person-centered service plan of care that reflects the services and supports, and the delivery of such services and supports, which are important to the individual. The individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the individual are included in the planning.

(2) Contractor shall provide necessary information in plain language in a manner accessible to individuals with disabilities and individuals whose English proficiency is limited. Cultural factors must be considered and accommodated.

(3) Contractor shall prepare the written PCSP commensurate with the individual's level of need and the scope of the services and supports available that reflects the Recipient's strengths and preferences and includes individually identified goals and desired outcomes.

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Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency (Cont)

- (4) Contractor shall describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.
- (5) Contractor shall include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies.
- (6) Contractor shall document and justify any modification that supports a specific and individualized assessed need.
- OHA reserves the right to approve, suspend, reduce, deny or terminate services with appropriate notice and fair hearing rights provided.

- 9. Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	IQA			

Services

- 1. State plan HCBS.** (*Complete the following table for each service. Copy table as needed*):

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Community-Based Integrated Supports
Service Definition (Scope):	
"Community Based Integrated Supports (CBIS)" means services <u>and supports</u> offered to individuals that provide assistance in acquisition, retention, or improvement with life management and socialization skills and community integration and engagement to	

§1915(i) HCBS State plan Services
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Community-Based Integrated Supports (Cont)

maintain their maximum functional level of functioning and integration within the broader community. These services include:

- Supervision, support, training, and assistance necessary for an individual to develop, maintain or improve skills and competencies necessary to function as independently as possible in the following areas:
 - o Managing their own behavior;
 - o Financial literacy;
 - o Social skills;
 - o Communication;
 - o Therapeutic activities, consistent with other mental health services; and
 - o Community integration and access.
- Home and Community-Based skill building service. These services assist an individual to build the skills and complete tasks for themselves rather than completing tasks for an individual.

CBIS may be provided via telehealth/telemedicine, in lieu of in-person visits, in accordance with HIPAA, and in accordance with OAR 410-172-0850.

CBIS are available and must be provided in the broader community to individuals residing in their own home. Services are provided by qualified providers as directed in the individual's PCSP.

Additional needs-based criteria for receiving the service, if applicable (specify):

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Community-Based Integrated Supports (Cont)

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):

<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Licensed Qualified Mental Health Professional	License types are outlined in OAR 410-172-0660(4)	N/A	Required to be licensed by their respective boards, not to include board-registered intern or associate designations, and be Medicaid enrolled as a community 1915(i) plan provider.
Certified Behavioral Health Organization	N/A	Organizational Certificate of Approval issued by the Health Systems Division as described in OAR chapter 309 division 8	Required to be Medicaid enrolled as a community 1915(i) plan provider.
Enrolled In-Home Care Agency	N/A	N/A	Required to be Medicaid enrolled as a community 1915(i) plan provider.

§1915(i) State plan HCBS
State/Territory: Oregon

Community-Based Integrated Supports (Cont)

Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Licensed QMHP	State of Oregon Medical Board Oregon Board of Nursing Oregon Board of Psychology Oregon Board of Licensed Professional Counselors and Therapists Oregon Board of Licensed Social Workers Oregon Board of Licensed Social Workers as described in OAR 877-015-0105 Oregon Occupational Therapy Licensing Board	Every two years
Certified Behavioral Health Organization	Health Systems Division	Every three years
Enrolled In-Home Care Agency	OHA, Public Health Division	Annual
Service Delivery Method		
<input type="checkbox"/> Participant-directed <input checked="" type="checkbox"/> Provider managed		

§1915(i) State plan HCBS
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Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	HCBS Residential Habilitation
Service Definition (Scope):	
<p>Services include:</p> <ul style="list-style-type: none"> ○ Identifying and completing ADL/IADL and/or nurse delegation tasks as defined in OAR 410-173-0005, 309-035-0105 and 309-035-0215. Skilled services delegated by a Registered Nurse (RN) under Oregon’s Nurse Practice Act may be considered personal care services and included in HCBS Residential Habilitation when the RN provides appropriate training and delegation of the listed nursing tasks in accordance with the Oregon Nurse Practice Act (OAR Chapter 851 Division 047). Completing ADL/IADL and/or nurse delegation tasks includes a range of assistance, based on assessed need, provided to persons with disabilities and chronic conditions that enables them to accomplish ADL/IADL tasks they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance, supervision and/or cueing. ○ Supporting individual to manage behaviors. ○ Activity Therapy -Group and generalized services administered by a qualified provider such as expressive, art, dance, exercise or play therapies provided for reasons other than recreation and that result in the improvement or reduction of the symptoms associated with a diagnosed behavioral health condition. ○ Life Management skills; ○ Socialization skills; and ○ Community Integration and Engagement. <p>HCBS Residential Habilitation services enable an individual to attain or maintain their maximum functional level and include:</p> <ul style="list-style-type: none"> ○ Supervision, support, training, and assistance necessary for an individual to develop, maintain or improve skills and competencies necessary to function as independently as possible in the following areas: <ol style="list-style-type: none"> 1. Managing their own behavior; 2. Financial literacy; 3. Social skills; 4. Communication; 	

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HCBS Residential Habilitation (Cont)

- 5. Therapeutic activities, consistent with other mental health services; and
- 6. Community integration and access.
 - Home and Community-Based skill building service. These services assist an individual to build the skills and complete tasks for themselves.
 - Primary purpose is to assist an individual access and integrate into the community;

Services may be delivered in the following settings by qualified providers:

- Broader community;
- OHA-licensed Residential Treatment Facilities (not Secure Residential Treatment Facilities);
- OHA, BH licensed Residential Treatment Homes;
- OHA, BH licensed Adult Foster Homes;
- ODHS, APD licensed Adult Foster Homes;
- ODHS, ODDS licensed Adult Foster Homes
- ODHS, APD licensed Residential Care Facilities;
- ODHS, APD licensed Assisted Living Facilities; and
- ODHS, ODDS certified Group Care Homes and State Operated Group Homes for Adults

Individuals receiving these services would not qualify for similar services funded under section 110 of Rehabilitation Act 1973 or Individual with Disabilities Improvement Act of 2004.

HCBS Residential Habilitation may be provided via telehealth/telemedicine, in lieu of in-person visits, in accordance with HIPAA, and in accordance with OAR 410-172-0850.

Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The States MMIS system includes edits to prevent duplicate billing. OHA's contractor also complete prior authorization reviews for both HCBS Residential Habilitation and In-Home Personal Care to also prevent duplicate approvals and billings.

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HCBS Residential Habilitation (Cont)			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Mental Health Adult Foster Home	OHA		OAR 309-040-0000
Residential Treatment Home or Facility	OHA		OAR 309-035-0300
APD and ODDS Adult Foster Care	ODHS		OAR 411-050-0600 through 0690 OAR 411-360-0010 through 411-360-0310
APD Residential Care Facility	ODHS		OAR 411-054-0000 through 0300
APD Assisted Living Facility	ODHS		OAR 411-054-0000 through 0300
ODDS Group Care Homes and State Operated Group Homes for Adults	ODHS	ODHS	OAR 411-325-0010 through 0480

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§1915(i) State plan HCBS
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HCBS Residential Habilitation (Cont)

Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Mental Health Adult Foster Home	Health Services Division	Every year
Residential Treatment Facility/Home	Health Services Division	Every two years
APD and ODD Adult Foster Care	Local CDDPs, Branch offices and DHS Central Office	Annually
Residential Care Facility	DHS Client Care Monitoring Unit	Every two years
Assisted Living Facility	DHS Client Care Monitoring Unit	Every two years
Group Care Home and State Operated Group Homes for Adults	DHS Central Office	Biennially
Service Delivery Method		
<input type="checkbox"/> Participant-directed <input checked="" type="checkbox"/> Provider managed		

§1915(i) State plan HCBS
 State/Territory: Oregon

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	HCBS Psychosocial Rehabilitation for persons w. CMI
Service Definition (Scope):	
<p>Services include:</p> <ul style="list-style-type: none"> • Comprehensive Medication Services (LMP) • Individual Therapy • Group Therapy • Family Therapy • Psychiatric Skills Training • Behavioral health counseling therapy • Psychiatric Activity Therapy/Community Psychiatric Supportive Treatment- Individualized and specific services administered by a qualified provider that promote community stabilization, integration, socialization, inclusion and skill acquisition to improve a person’s ability to engage in community, home, school, work and family and overall integration and contribution to their community. <p>Assertive Community Treatment (OAR Chapter 309 Division 019)</p> <p>HCBS Psychosocial Rehabilitation may be provided via telehealth/telemedicine, in lieu of in-person visits, and in accordance with HIPAA, as directed by OHA.</p> <p>Psychosocial rehabilitation services under the 1915(i) differ in nature, scope, supervision arrangements, and provider type (including provider training and qualifications) from psychosocial rehabilitation services otherwise available in the state plan.</p>	
Additional needs-based criteria for receiving the service, if applicable (specify):	

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HCBS Psychosocial Rehabilitation for persons w. CMI (Cont)

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Mental Health Adult Foster Home	OHA		OAR 309-040-0000
Residential Treatment Home or Facility	OHA		OAR 309-035-0300
Residential Care Facility	DHS		OAR 411-054-0000 through 0300
Mental Health Adult Foster Home	OHA		OAR 309-040-0000
Licensed Qualified Mental Health Professional	License types are outlined in OAR 410-172-0660(4) Board of Nursing; Occupational Therapy Licensing Board	N/A 410-172-0660	Required to be licensed by their respective boards, not to include board-registered intern or associate designations, and be Medicaid enrolled as a mental health provider, within the scope of their training.

§1915(i) State plan HCBS
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HCBS Psychosocial Rehabilitation for individuals w CMI (Cont)

Provider Qualifications (For each type of provider. Copy rows as needed):			
<i>Provider Type (Specify):</i>	<i>License (Specify):</i>	<i>Certification (Specify):</i>	<i>Other Standard (Specify):</i>
Certified Behavioral Health Organization	N/A	Organizational Certificate of Approval issued by the Health Systems Division as described in OAR chapter 309 division 8	Required to be Medicaid enrolled as a community 1915(i) plan provider.
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
<i>Provider Type (Specify):</i>	<i>Entity Responsible for Verification (Specify):</i>		<i>Frequency of Verification (Specify):</i>
Mental Health Adult Foster Home	Health Systems Division		Every year
Residential Treatment Facility/Home	Health Systems Division		Every two years
Residential Care Facility	DHS Client Care Monitoring Unit		Every two years
Licensed Qualified Mental Health Provider	Health Systems Division		Every three years
Certified Behavioral Health Organization	Health Systems Division		Every three years
Additional needs-based criteria for receiving the service, if applicable (specify):			

§1915(i) State plan HCBS
State/Territory: Oregon

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	HCBS In-Home Personal Care
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Service Definition (Scope):

HCBS In-Home Personal Care (IHPC) are direct services that assist an individual to accomplish Activities of Daily Living and/or Instrumental Activities of Daily Living (ADL/IADL) tasks in home settings and the broader community. IHPC do not include services that assist an individual with the acquisition, retention and improvement of the skills needed to accomplish ADL/IADL tasks.

Scope of Services

Individuals exercise Employer Authority in HCBS In-Home Personal Care services. Individuals may find their own candidates for employment, screen otherwise qualified candidates for ability to meet participant needs, hire, supervise, direct and discharge employees enrolled as Personal Care Attendants. Participants establish work schedules and train employees in how they prefer to receive their services.

IHPC include a range of assistance, based on assessed need, provided to persons with disabilities and chronic conditions that enables them to accomplish ADL/IADL tasks they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance, supervision and/or cueing.

Unlike 1905(a) Personal Care services, HCBS IHPC services are authorized using a person-centered planning process and offer participant direction opportunities.

ADLs include; eating, bathing, dressing, toileting, maintaining continence, and mobility and transferring. IADLs capture more complex life activities and include; personal hygiene, light housework, laundry, meal preparation, shopping, using electronic communication devices, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions.

Skilled services delegated by a Registered Nurse (RN) under Oregon’s Nurse Practice Act may be considered personal care services when the RN provides appropriate training and delegation of the listed nursing tasks in accordance with the Oregon Nurse Practice Act (OAR Chapter 851 Division 047).

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HCBS In-Home Personal Care (Cont)

Cognitive Impairments	
<p>An individual may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal assistance may include cueing and supervision to support the individual while performing the task. This does not include, or replace, community-based integrated support services that support the individual to develop the skills needed to complete the task independently.</p>	
<p>Oregon is in compliance with Electronic Visit Verification Systems (EVV) requirements in accordance with section 12006 of the 21st Century CURES Act.</p>	
<p>Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):</p>	
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):</p>	
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

§1915(i) State plan HCBS
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HCBS In-Home Personal Care (Cont)

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type <i>(Specify)</i> :	License <i>(Specify)</i> :	Certification <i>(Specify)</i> :	Other Standard <i>(Specify)</i> :
Personal Care Attendant	N/A	N/A	Requirements for qualification at Oregon Administrative Rule 410-172-0810
In-home Care Agency	OAR 333-536-0010	N/A	Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-1505 and OAR 410-120-1260
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type <i>(Specify)</i> :	Entity Responsible for Verification <i>(Specify)</i> :		Frequency of Verification <i>(Specify)</i> :
Personal Care Attendant	OHA		Biennial background check, Revalidation every 5 years.
In-home Care Agency	OHA, Public Health Division		Annual
Service Delivery Method			
<input checked="" type="checkbox"/> Participant-directed <input type="checkbox"/> Provider managed			
Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Community Transportation		
Service Definition (Scope):			
Community Transportation is provided to eligible individuals to gain access to community-based services, activities, and resources. Trips are related to person-centered service plan needs, are not covered in the 1115 medical benefit, are not for the benefit of others in the household and are provided in the most cost-effective manner that will meet needs specified on the plan. Community Transportation services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individual; 2) compensate the service provider for travel to or from the service provider's home. Providers in licensed settings are to provide or arrange for transportation if the individual cannot.			
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :			

§1915(i) State plan HCBS
State/Territory: Oregon

Community Transportation (Cont)

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):

<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Common Transportation Carriers, taxi, bus	N/A	N/A	In accordance with standards established for those transportation entities.
In-home Care Agency Provider	OAR 333-536-0010	N/A	Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-0400 and OAR 410-120-1260
Personal Care Attendant	N/A	N/A	Requirements for qualification at Oregon Administrative Rule 410-172-0810

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):
Common transportation carriers, taxi, bus	Contractor (IQA)	Prior to service authorization
In-home Care Agency Provider	Public Health Division	Annual
Personal Care Attendant	Contractor (IQA)	Prior to service authorization

Service Delivery Method

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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§1915(i) State plan HCBS
State/Territory: Oregon

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):			
Service Title:		Home Delivered Meals	
Service Definition (Scope):			
Home Delivered Meals are provided for participants who live in their own homes, are home-bound, are unable to do meal preparation, and do not have another person available for meal preparation. Provision of the home delivered meal reduces the need for reliance on paid staff during some mealtimes by providing meals in a cost-effective manner.			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	Home delivered meals are not available to individuals residing in a setting in which residential providers are responsible to provide meals.		
	Home delivered meals are limited to one per day.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
HDM provider	N/A	N/A	Criteria at 411-040-0030
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
HDM provider	Contractor		Prior authorization
Service Delivery Method			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

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§1915(i) State plan HCBS
 State/Territory: Oregon

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Housing Support Services
Service Definition (Scope):	
<p>Housing supports services are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the goal of maintaining an individual’s personal health and welfare in a home and community-based setting where the person is directly responsible for his or her own living expenses.</p> <p>Housing supports services may include one or more of the following components if they are not otherwise available:</p> <p>Individual Housing and Tenancy Sustaining Services:</p> <ul style="list-style-type: none"> • Coordination with the individual to plan, participate in, review, update and modify their individualized housing support plan on a regular basis, including at redetermination and/or revision plan meetings, to reflect current needs and preferences and address existing or recurring housing retention barriers. • Providing assistance with securing and maintaining entitlements and benefits (including rental assistance) necessary to maintain community integration and housing stability (e.g., assisting individuals in obtaining documentation, assistance with completing documentation, navigating the process to secure and maintain benefits, and coordinating with the entitlement/benefit assistance agency). • Assistance with securing supports to preserve the most independent living. • Monitoring and follow-up to ensure that linkages are established, and services are addressing housing needs. • Providing supports to assist the individual in the development of independent living skills to remain in the most integrated setting (e.g., skills coaching to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation). • Providing supports to assist the individual in communicating with the landlord and/or property manager. • Education and training on the role, rights, and responsibilities of the tenant and landlord. • Providing training and resources to assist the individual with complying with his/her lease. 	

§1915(i) State plan HCBS
State/Territory: Oregon

Housing Support Services (Cont)

- Assisting in reducing the risk of eviction by providing services to prevent eviction (e.g., to improve conflict resolution skills; coaching; role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicating with landlords and neighbors to reduce the risk of eviction; addressing biopsychosocial behaviors that put housing at risk; providing ongoing support with activities related to household management; and linking the tenant to community resources to prevent eviction).
- Providing early identification and intervention for actions or behaviors that may jeopardize housing.
- Providing a pest eradication treatment, no more than one time per year that is necessary for the individual's health and safety as documented by a health care professional. This service is not intended for pre-tenancy, monthly, routine or ongoing treatments. This service is coverable when the individual is living in their own home, when not already included in a lease, and when the pest eradication is for the management of health and safety as identified in the person-centered service plan.
- Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health, and when modification is not covered by another entity as required by law.
- Assistance with connecting the enrollee to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

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Housing Support Services (Cont)

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):

<input checked="" type="checkbox"/>	<p>Categorically needy (specify limits):</p> <p>Services not included in the Housing Benefit:</p> <ol style="list-style-type: none"> 1. Payment of ongoing rent or other room and board costs. 2. Capital costs related to the development or modification of housing. 3. Expenses for utilities or other regular occurring bills. 4. Goods or services intended for leisure or recreation. 5. Duplicative services from other state or federal programs. 6. Services to individuals in a correctional institution or an Institution of Mental Disease (IMD) (other than services that meet the exception to the IMD exclusion), or in an institutional setting.
<input type="checkbox"/>	<p>Medically needy (specify limits):</p>

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Housing Supports	N/A	N/A	<p>Education (e.g., Bachelor’s degree, Associate’s degree, certificate) in a Human/social services field or a relevant field; and/or</p> <p>At least one year of relevant professional experience and/or training in the field of service.</p> <p>Knowledge of principles, methods, and procedures of services included under housing supports services, or comparable services meant to support an individual’s ability to obtain and maintain stable housing.</p>

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Housing Support Services (Cont)

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
General business (includes retail/online stores, property managers, utility companies)	N/A	N/A	Any required license, certification or other state required standard to operate the type of business relevant to the item or service being requested. For example, payments for utilities must be made to a utility provider that is authorized to operate in the State of Oregon. The utility provider maintains all appropriate licenses, certifications, etc. to operate as a utility provider in the State. Providers completing necessary home accessibility adaptations must be licensed, bonded and insured. General contractors must have current Construction Contractors Board (CCB) license.
Self-employed Registered Nurse	Current and unencumbered nursing license who meets Oregon State Board of Nursing licensure requirements under Oregon Revised Statute 678.010 – 410 and Oregon Administrative Rules, Standards and Scope of Practice for Licensed Nursing		Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-0400 and OAR 410-120-1260.

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Housing Support Services (Cont)

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
In Home Care Agency (ORS 443.305)	OAR Chapter 333, Division 536		Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-0400 and OAR 410-120-1260.
Home Health Agency (ORS 443.005)	OAR Chapter 333, Division 27		

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):		
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
General Business	IQA	Prior to authorization of payment for good or service.
Housing Supports Provider	IQA	Prior to Authorization
In Home Care Agency (ORS 443.305)	OHA	Prior to payment through the MMIS system with nursing license verification occurring every two years and Medicaid provider re-enrollment every five years
Service Delivery Method		
<input type="checkbox"/> Participant-directed <input checked="" type="checkbox"/> Provider managed		

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Transition Services
Service Definition (Scope):	
<p>Community Transition Services:</p> <p>Community Transition Services are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the goal of maintaining an individual’s personal health and welfare in a home and community-based setting as they are transitioning from an institutional setting, Adult Foster home, Residential Treatment Facility, or Residential Treatment Home to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.</p> <p>Supports also cover expenses necessary to enable individuals to obtain an independent, community-based living setting. Specifically, allowable expenses may include: deposits required to obtain a lease on an apartment or home; essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess need, arrange for, and procure needed resources. Food benefit is limited to situations where other resources are not available to the consumer through SNAP or local food security resources or until SNAP benefits are issued). Basic clothing benefit is limited to essential items not already available to the consumer.</p> <p>1915(i) Community Transition Service coordination may be provided to individuals transitioning from allowable institutional settings up to 180 days prior to discharge and the individual is eligible for and receiving 1915(i) services after discharge from the institutional setting. FFP for Community transition Service coordination will not be claimed for services provided to individuals between ages 22 and 64 who are served in IMDs or individuals who are inmates of public institutions.</p>	
Additional needs-based criteria for receiving the service, if applicable (specify):	

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Transition services (Cont)

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):

<input checked="" type="checkbox"/>	<p>Categorically needy (<i>specify limits</i>):</p> <ol style="list-style-type: none"> 1. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources, including natural supports. 2. Community Transition Services do not include ongoing monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. 3. Community Transition services are only available up to 180 days prior to discharge from an institutional setting.
<input type="checkbox"/>	<p>Medically needy (<i>specify limits</i>):</p>

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Housing Supports	N/A	N/A	Education (e.g., Bachelor's degree, Associate's degree, certificate) in a Human/social services field or a relevant field; and/or At least one year of relevant professional experience and/or training in the field of service. Knowledge of principles, methods, and procedures of services included under housing supports services, or comparable services meant to support an individual's ability to obtain and maintain stable housing.

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Transition services (Cont)

Provider Qualifications (For each type of provider. Copy rows as needed):			
<i>Provider Type (Specify):</i>	<i>License (Specify):</i>	<i>Certification (Specify):</i>	<i>Other Standard (Specify):</i>
General business (includes retail/online stores, property managers, utility companies)	N/A	N/A	Any required license, certification or other state required standard to operate the type of business relevant to the item or service being requested. For example, payments for utilities must be made to a utility provider that is authorized to operate in the State of Oregon. The utility provider maintains all appropriate licenses, certifications, etc. to operate as a utility provider in the State. Providers completing necessary home accessibility adaptations must be licensed, bonded and insured. General contractors must have current Construction Contractors Board (CCB) license.
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
<i>Provider Type (Specify):</i>	<i>Entity Responsible for Verification (Specify):</i>		<i>Frequency of Verification (Specify):</i>
Housing Supports Provider	IQA		Prior to Authorization
General Business Contractor	IQA		Prior to authorization of payment for good or service.
Service Delivery Method			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):			
Service Title:		Pest Eradication Services	
Service Definition (Scope):			
Pest eradication treatment, no more than one time per year that is necessary for the individual's health and safety as documented by a health care professional. This service is not intended for pre-tenancy, monthly, routine or ongoing treatments. This service is coverable when the individual is currently living in their own home, when not already included in a lease, and when the pest eradication is for the management of health and safety as identified in the person-centered service plan.			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	Home delivered meals are not available to individuals residing in a setting in which residential providers are responsible to provide meals. Home delivered meals are limited to one per day.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Pest Eradication Service	Annual License as described in OAR Chapter 603 Division 57	N/A	N/A
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Pest Eradication Service	Housing Support Provider		Prior to service authorization
Service Delivery Method			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

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2. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

All 1915(i) HCBS residential and IHPC services require prior authorization prior to service delivery or payment.

(a) Providers who can be paid for 1915(i) services must meet all necessary Provider Qualifications for the service which they are providing in accordance with OAR. Providers must be enrolled as a Medicaid provider and have a history of providing HCBS to other HCBS recipients; and other or alternative Community-Based Integrated Supports resources are not available to meet the participant's needs as defined in their plan of care.

(b) the 1915(i) services provided are Community-Based Integrated Supports;

(c) OHA ensures that the provision of services by such persons is in the best interest of the individual by increased service monitoring offering of choice of qualified providers and service settings will be part of the person-centered planning process. Assessments and person-centered service plans are directed by the individual so any concerns about the service provider, relative or not, are documented and addressed at the individual's request.

(d) As stated in (c) above, when HCBS In-home Personal Care is provided by relatives, legal guardians, and legally authorized representatives service monitoring and coordination by the IQA will be increased and ongoing offering of choice of qualified providers and service settings will be part of the participants' person-centered planning process.

(e) OHA has administrative rules in place regarding prior authorization, billing and payment and post payment review to ensure services are rendered prior to payment. Additionally, OHA's MMIS contains multiple automated functions to ensure payments will be made to a relative of the participant only if they meet the requirements in (a) and (b) above.

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Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians (Cont)

(f) OHA will ensure reimbursement of services provided by relatives, legal guardians, and legally authorized representatives will only be made for services rendered by: requiring prior authorization and post payment review activities to be conducted by the independent entity; and OHA will maintain prior authorization and post payment review policies and procedures based on applicable administrative rule for reimbursement of HCBS services and the contract between OHA and the independent entity.

Relatives, legal guardians, and legally authorized representatives may provide specified services and are required to meet the provider qualifications set forth in Oregon Administrative Rule. Relatives, legal guardians, and legally authorized representatives may be paid when a conflict of interest is not present the relative meets the qualifications for the service provided and is chosen by the individual. Exceptions to this policy may only be granted by HSD. Requests for exception must be submitted to HSD. Requests should include a demonstration of effort to resolve any conflicts of interest through a thorough exploration of service setting options, a thorough exploration of available providers, and an inability to locate a qualified and willing designated representative.

Relatives may provide the services identified for which they meet provider qualifications, based on the individual's assessed needs and identified in the approved Person-Centered Service Plan. Services provided, regardless of the provider, must be in accordance with any limits identified in the waiver and set forth in OAR.

Relatives, legal guardians and legally authorized representatives who are identified as providers in the service plan are verified as being in the best interest of the individual by the individual, legal representative, or authorized representative, and case manager. Anyone identified as a provider, including relatives, legal guardians, and legally authorized representatives cannot be responsible for directing Person-Centered Service Plan development. When a legal guardian is paid to be a provider of 1915(i) services, another person must be designated as a representative for the purpose of developing the Person-Centered Service Plan.

All providers, including relatives, legal guardians, and legally authorized representatives provide services in accordance with authorized and signed Person-Centered Service Plan. All providers will record time and dates of services using the State's approved electronic visit verification system.

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Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (Select one):

<input type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input checked="" type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i>
	Employer authority for Personal Care Attendants providing HCBS In-Home Personal Care.

1. Description of Participant-Direction (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

<p>(a) Nature of opportunities for participant direction. OHA provides opportunities for participants to exercise Employer Authority in HCBS In-Home Personal Care services. Participants may find their own candidates for employment, screen otherwise qualified candidates for ability to meet participant needs, hire, supervise, direct and discharge employees enrolled as Personal Care Attendants. Participants establish work schedules and train employees in how they prefer to receive their services.</p> <p>(b) Process for accessing participant-directed services. The IQA case manager will discuss various services options with every eligible individual/legal representative who chooses home and community-based services. When the preference is to receive services at home, the IQA case manager will inform the individual/legal representative of the option to receive them from a Personal Care Attendant or an in-home care agency.</p> <p>(c) Entities involved in supporting participant direction and supports provided.</p>

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Description of Participant-Direction (Cont)

1) Information and assistance in support of participant direction:

- IQA case manager and/or OHA provides referral lists of Personal Care Attendants who have met minimum qualifications for enrollment including a criminal history check conducted by OHA.
- A contract RN, if referred by the IQA case manager, clinician or CMHP may also provide care assistance training and teaching opportunities to both the participant-employer and the Personal Care Attendant employee. Under Oregon law, contract RNs are also able to delegate certain nursing tasks to the Personal Care Attendant employee such as insulin injections.
- The Oregon Home Care Commission (OHCC) publishes “The Consumer-Employer Training Guide” which is provided to participants to assist them in carrying out the responsibilities of being the employer of the Personal Care Attendant employee.
- The participant-employer may also request further assistance of the OHCC in working with Personal Care Attendant employees.
- Most local Oregon Department of Human Services local offices have developed an orientation for Personal Care Attendants. If the local office does not directly offer the orientation, the orientation is offered at a central location, accessible by potential Personal Care Attendants. OHCC has prepared and distributed a guide for Personal Care Attendants. The guide explains the program, roles of the agency, and responsibilities of the provider. Each provider in the program also signs a provider enrollment form which further describes conditions of payment.
- OHA issues payment to the Personal Care Attendant employee and addresses tax and other employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on a monthly voucher verifying the number of hours their employee worked, up to the maximum monthly hours authorized by the IQA.
- The IQA case manager provides a task list to the individual and Personal Care Attendant based on the person-centered service plan.

The IQA case manager monitors the service plan, identifying risks and unmet needs and discussing options with individuals. At a minimum, reassessments of needs are completed once a year. IQA case managers are expected to identify and monitor more closely if the situation warrants, for example if the individual’s health is fragile, if there are provider issues, mental health stability concerns or protective service issues.

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Description of Participant-Direction (Cont)

The participant has the right to fire the worker at any time, for any reason. The IQA case manager may alter the services authorized based on reassessments of the participant’s needs. In that situation, the IQA or OHA sends a notice of reduction or termination of services to the participant. The IQA or OHA also sends a notice to the worker if the hours change.

2. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input checked="" type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the state affected by this option):</i>

3. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
HCBS In-Home Personal Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

4. Financial Management. *(Select one):*

<input checked="" type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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5. **Participant-Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:
- Specifies the State plan HCBS that the individual will be responsible for directing;
 - Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
 - Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
 - Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
 - Specifies the financial management supports to be provided.
7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

Voluntary Termination of Participant Direction-

Individuals may voluntarily terminate their self-directed services at any time. When an individual chooses to terminate their employer responsibilities, the IQA case manager will discuss the available service options provided by In-Home Care Agency providers and will update the Person-Centered Service Plan.

Involuntary Termination of Participant Direction-

An individual may have their employer authority terminated when they are unable to meet the responsibilities of being an employer as evidenced by such things as:

(A) Independent provider complaints;

(B) Multiple complaints from an independent provider requiring intervention from OHA or IQA; intervention include such actions as:

(a) A documented review of the employer responsibilities

(b) Training related to employer responsibilities;

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Voluntary and Involuntary Termination of Participant-Direction (Cont)

- (c) Corrective action taken as a result of an independent provider filing a complaint with OHA or OHA's designee, or other agency who may receive labor related complaints;
 - (d) Identifying a representative if an individual is not able to meet the employer responsibilities described in number 2 of this section (Participant-Direction of Services); or
 - (e) Identifying another representative if an individual's current representative is not able to meet the employer responsibilities described in number 2 of this section (Participant-Direction of Services).
- (C) Frequent errors on time sheets, mileage logs, or other required documents submitted for payment that results in repeated coaching from the OHA or IQA;
- (D) Complaints to Medicaid Fraud involving the individual or the individual's representative; or
- (E) Documented observation by the IQA of services not being delivered as identified in the individual's PCSP.

When employer authority is removed, the identified support needs can be met using services available from provider types that do not have an employment relationship with the individual. Specific providers of these types may be selected from those available by the individual or the individual's legal representative. Participant direction of these providers will be encouraged and allowed to the greatest extent possible. The individual's case manager will revise the previously authorized Person-Centered Service Plan to assure all support needs formerly met by the Personal Care Attendant will be met by the new provider type.

If the individual chooses not to utilize the alternate provider types or alternate provider types are unavailable, the individual or the individual's legal representative will be advised of options for meeting identified needs through other home and community-based services. Individuals will be informed of the opportunity to request a Medicaid Fair Hearing.

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8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). *(Select one):*

<input type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input checked="" type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input checked="" type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). *(Select one):*

<input checked="" type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):</i>
	Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.</i>

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Quality Improvement Strategy

Quality Measures

(Describe the state’s quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

- 1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Service plans a) address assessed needs of 1915(i) participants;
Discovery	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>(1) Number and percent of participants whose type of services are delivered in accordance with the service plan. N: Number of participants whose services were delivered in the type, scope, amount, duration and frequency in accordance with the service plan. D: Total number of participants service plans reviewed</p> <p>(2) Number and percent of participants whose scope of services are delivered in accordance with the service plans in which risks, and safety factors are addressed N: Number of service plans in which risks, and safety factors are addressed D: Total number of service plans reviewed</p> <p>(3) Number and percent of participants whose duration of services are delivered in accordance with the service plans which include services and supports that address assessed needs. N: Number of participants whose service plans include services and supports that address assessed needs. D: Total number of participants reviewed.</p> <p>(4) Number and percent of participants whose frequency of services are delivered in accordance with the service plans which address personal goals and preferences. N: Number of service plans in which personal goals and preferences are addressed. D: Total number of service plans reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Data Source: Record Review – Off-site</p> <p>Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.</p>

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Service plans a) (Cont)

Requirement	Service plans a) address assessed needs of 1915(i) participants;
Discovery	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD MPU
Frequency	QTRLY
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy.</p> <p>(2) Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis.</p> <p>(3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by HSD to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.</p>
Frequency <i>(of Analysis and Aggregation)</i>	<p>Contractor submits quarterly reports to HSD. HSD reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy.</p> <p>Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)</p>

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Requirement	Service plans b) are updated annually;
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	(1) Number and percent of service plans that were revised/updated based on change in the individual’s condition; N: Service plans revised/updated based on change in individuals’ condition. D: Number of services plans reviewed. (2) Number and percent of service plans revised/updated within 12 months. N: Number of service plans that were updated/revised within 12 months. D: Total number of service plans reviewed
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD MPU
Frequency	QTRLY
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by HSD to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.

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State/Territory: Oregon

Service plans b) (Cont)

Remediation	
Frequency <i>(of Analysis and Aggregation)</i>	<p>Contractor submits quarterly reports to HSD. HSD reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy.</p> <p>Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)</p>
Requirement	Service plans c) document choice of services and providers
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	(1) Number and percent of participants who are offered choice among services and providers N: Number of participants who are offered choice among services and providers D: Total number of files reviewed
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Data Source: Record Review – Off-site</p> <p>Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD MPU
Frequency	Annually

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State/Territory: Oregon

Requirement	Service plans c) document choice of services and providers (Cont)
Remediation	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy.</p> <p>(2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis.</p> <p>(3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by HSD to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Contractor submits quarterly reports to HSD. HSD reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy.</p> <p>Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)</p>

§1915(i) State plan HCBS
 State/Territory: Oregon

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of files reviewed documenting individuals who have a reasonable indication of need for 1915(i) HCBS services have an evaluation for 1915(i) HCBS eligibility. N: Number of individuals who have a reasonable indication of need for 1915(i) HCBS services who are evaluated for 1915(i) eligibility. D: Total number of files reviewed
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD MPU
Frequency	QRTL

§1915(i) State plan HCBS
 State/Territory: Oregon

Eligibility Requirements: (a) (Cont)

Remediation	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy.</p> <p>(2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis.</p> <p>(3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by HSD to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Contractor submits quarterly reports to HSD. HSD reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy.</p> <p>Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).</p>

§1915(i) State plan HCBS
State/Territory: Oregon

Requirement		Eligibility Requirements: (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately;
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of files reviewed that document the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately. N: Files reviewed that document that eligibility is determined using the processes and instruments described in the approved state plan. D: Total number of files reviewed
	Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD MPU
	Frequency	QRTLTY
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by HSD to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.

§1915(i) State plan HCBS
State/Territory: Oregon

Eligibility Requirements: (b) (Cont)

<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Contractor submits quarterly reports to HSD. HSD reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy.</p> <p>Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)</p>
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<p>Requirement</p>	<p>Eligibility Requirements: (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS</p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of individuals reevaluated for 1915(i) eligibility annually.</p> <p>N: Number and percent of individual files documenting annual reevaluation of 1915(i) eligibility.</p> <p>D: Number of files reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Data Source: Record Review – Off-site</p> <p>Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.</p>

§1915(i) State plan HCBS
State/Territory: Oregon

Eligibility Requirements: (c) (Cont)

<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>HSD MPU</p>
<p>Frequency</p>	<p>QRTLTY</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy.</p> <p>(2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis.</p> <p>(3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by HSD to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Contractor submits quarterly reports to HSD. HSD reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy.</p> <p>Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)</p>

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3. Providers meet required qualifications. *(Table repeats for each measure for each requirement and lettered sub-requirement above.)*

Requirement	Providers meet required qualifications.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of providers who meet required provider qualifications N: Number of providers who meet required provider qualifications D: Total number of providers reviewed
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Licensing/Certification visits conducted by OHA, HSD. Sampling Approach: 100% review of sites conducted at least biennially.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD Licensing and Certification Unit for OHA licensed/certified providers HSD, Provider Enrollment Unit for non-licensed provider types, i.e Personal Care Attendants. ODHS, APD and ODDS licensing Units for ODHS licensed/certified residential providers.
Frequency	RTFs and RTHs reviewed every 2 years, AFHs reviewed every year. Non-licensed providers reviewed every two years for background check and every 5 years for all other requirements.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	If provider is not in compliance with minimum requirements, provider must take corrective action. Non-compliance with approved corrective action will lead HSD to work with MHOs to seek alternate services and informing the License/ Cert Unit for possible action.
Frequency <i>(of Analysis and Aggregation)</i>	Provider must take corrective action and notify HSD of completion of corrective action within time frames specified in the notice of violation as described in licensing rules for the setting.

§1915(i) State plan HCBS
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4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	Settings meet the home and community-based setting requirements as specified in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	PM: Number and percent of HCBS settings that meet Federal HCBS settings requirements. N: Number of HCBS settings that meet Federal HCBS settings requirements. D: Number of HCBS settings reviewed.
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Licensing/Certification visits conducted by OHA, HSD. Licensing/Certification visits conducted by ODHS, APD and ODDS for settings licensed/certified by ODHS. Sampling Approach: 100% review of sites conducted at least biennially
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD Certification/ Licensing Unit and MPU ODHS, APD and ODDS licensing and certification units.
Frequency	Biennially
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	If provider is not in compliance with minimum requirements, provider must take corrective action. Non-compliance with approved corrective action will lead HSD to work with community mental health organizations to seek alternate services and informing the License/ Cert Unit for possible action.
Frequency <i>(of Analysis and Aggregation)</i>	Provider must make corrective action and notify HSD of completion of corrective action within time frames specified in the notice of violation as described in licensing rules for the setting.

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5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	The SMA retains authority and responsibility for program operations and oversight
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. N: Number of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. D: Number of aggregated performance measure reports, trends, and remediation efforts generated by IQA. Number and percent of discovered deficiencies resolved by OHA. Numerator – number and percent of deficiencies resolved by OHA when discovered during quality assurance reviews; Denominator – total number of all reports with discovered deficiencies after quality assurance review by OHA.
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Operating Agency Performance Review Sampling Approach: 100% of reports submitted to OHA by IQA
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD
Frequency	Annually
Remediation	
Remediation Responsibilities	Provide IQA with TA; review contract to ensure clarity of eligibility criteria
Frequency	within 15 days of the discovery of evidence

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State/Territory: Oregon

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	The state maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	(1) Number and percent of claims approved with appropriate plan of care as specified in the approved State Plan HCBS. N: Number of claims approved in accordance with the appropriate plan of care D: Total number of claims approved for files reviewed. (2) Number and percent of claims paid for services furnished by qualified providers. N: Paid claims furnished by qualified providers. D: Total paid claims reviewed
Discovery Activity <i>(Source of Data & sample size)</i>	Data Source: Record Review – On-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology. OR MMIS contains many edits which are applied automatically to claims to prevent inappropriately issuing a payment. These edits include a referring, billing and performing provider checks, prior authorization check (including POC) and diagnoses check.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	HSD
Frequency	ANNUALLY
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	100% of State Plan HCBS claims of participants that were not enrolled on the date of services are denied. Provide TA to providers on proper billing procedures and adjusting claims as needed
Frequency <i>(of Analysis and Aggregation)</i>	Within 90 days of the discovery of evidence

§1915(i) State plan HCBS
 State/Territory: Oregon

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement	The state identifies addresses and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>(1) Number and percent of State Plan HCBS complaints resolved within required guidelines N: Number of complaints resolved within required guidelines D: Total number of complaints reviewed</p> <p>(2) Number and percent of allegations regarding wrongful restraint and involuntary seclusion where investigations are conducted in accordance with OAR407-045-0320 N: Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow-up occurred D: Total number of files reviewed that included allegations of wrongful restraint and involuntary seclusion.</p> <p>(3) HSD requires and ensures 100% of staff working in a RTF, RTH or AFH are trained in Mandatory Abuse Reporting. Number and percent of providers who meet abuse reporting training requirements ongoing N: Number of providers who meet abuse reporting training requirements ongoing D: Total number of providers reviewed</p> <p>(4) Number and percent of participants and/or guardians who are informed about the ways to identify and report abuse, neglect and exploitation N: Number of participants and/or guardians who are informed about the ways in which to identify and report abuse, neglect and exploitation D: Total number of files</p> <p>(5) Number and percent of incidents reports that were filed appropriately (timely and according to policies and procedures). N: Number of incident reports completed appropriately (timely and according to policies and procedures) D: Total number of files reviewed which contained initial incident.</p>

§1915(i) State plan HCBS
State/Territory: Oregon

The state identifies, addresses, and seeks ...(Cont)

	<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>(1) CMHP submit QTRLY reports on Complaints. Will review for 1915(i) providers.</p> <p>(2) Immediate attention and response provided to receipt of call regarding a critical incident followed by a report via fax.</p> <p>(3) Data Source: Record Review – Off-site (applies to all five PM above)</p> <p>Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.</p>
	<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>HSD</p>
	<p>Frequency</p>	<p>QTRLY</p>

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The state identifies, addresses, and seeks ...(Cont)

Remediation	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>(1) If abuse cases are identified for specific provider agencies, HSD to review 100% of the residents' records of the identified provider agency to identify breadth of issue within 30 days. Provider must submit CAP within 15 days following completed review. Failure to make records available, non-compliance with approved CAP/failure to develop an approved CAP leads HSD/CMHP's to seek alternate services and informing the License/Cert Unit for action.</p> <p>(2) CMHP's submit QTRLY reports on complaints/grievances. HSD to review for 1915(i) related complaints/grievances.</p> <p>(3) Follow State protocol for any reported suspected occurrences of abuse, neglect or exploitation. HSD protocol is to forward any reported suspected abuse reports to State Office of Adult Abuse Prevention and Investigation (OAAPI) and partners with OAAPI on any supporting documentation needed. HSD receives ongoing status of any open cases by OAAPI and works in close partnership to ensure corrective actions are implemented.</p> <p>(4) HSD ensures 100% of staff working in an RTF, RTH, AFH are trained (by DHS OIT or designee) in Mandatory Abuse Reporting by requiring any staff not appropriately trained, receive the required training within 1 month of discovery.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>1) Upon discovery of failure to meet any participants' health and welfare; 2) Follow-up and TA within 60 days of the date of discovery; 3) Immediately with any reported occurrence until process is complete. 4) Upon discovery of less than 100% of staff not receiving mandatory abuse reporting training.</p>

§1915(i) State plan HCBS
State/Territory: Oregon

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

HSD will gather the discovery evidence on a quarterly and annual basis to identify trends in each focus area on the QIS. HSD will also look closely for any trends specific to a residence or residential category. HSD will respond to findings in the manner that would be the most appropriate.

For example, if a statewide issue is identified, HSD would implement an intervention best suited for the issue, be it statewide trainings and technical assistance or targeting an intervention for a specific workforce such as the county residential specialists.

Another method to effect desired change will be to work with the HSD Licensing and Certification and/or the HSD Provider Enrollment unit and their reviews to focus on identified areas for improvement.

The results of the data are public domain and participants may use it to inform their choice for one residence over another.

HSD will use the information gathered to determine what levels of care need more development, be it supported housing or strengthening interventions to promote independence.

HSD will prioritize the needs for system change by determining which areas for improvement will make the greatest improvement for the most participants in the program, furthering their level of independence.

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2. Roles and Responsibilities

HSD: Administer IQA contract and monitor IQA for performance and outcomes. HSD will monitor processes of enrollment, payment, licensing for compliance, quality and outcomes. HSD will respond to reported deficits through compliance activities, rule application, post payment review of paid services and reporting to other accountable agencies when applicable.

IQA: Will implement person centered assessment and planning. Ensure implementation of person-centered plans and report outcomes to HSD. Conduct medical appropriateness reviews of requested services. Ensure person centered planning guidelines are adhered to for authorized services. Gather and report QIS data for HSD.

LMHA / CMHP: Engage in processes for certification of providers. Monitor for health and safety. Provide technical assistance to providers and monitor for HCBS rule compliance.

Provider Agencies: Implement person centered plans. Deliver services. Maintain compliance with HCBS rules and Oregon Administrative Rule.

Participants: Participate in development of the person-centered plan. Provide feedback to providers, CMHP and HSD.

3. Frequency

The HSD Licensing and Certification unit follow specific frequencies of monitoring that are defined in OARs.

- Outpatient Services: Certificates of Approval are valid for a maximum of 3 years and HSD Provider Enrollment revalidates enrollments every five years;
- Residential Treatment Facilities & Homes: Licenses are valid for a maximum of 2 years and HSD Provider Enrollment revalidates enrollments every five years;
- Adult Foster Homes: Licenses are valid for a maximum of 1 year and HSD Provider Enrollment revalidates enrollments every five years;

Qualified Mental Health Professionals (QMHPs) are verified by the HSD Licensing and Certification Unit every 3 years and HSD Provider Enrollment revalidates enrollments every five years. Periodic or interim reviews can occur as needed when there is a concern about a program.

The other monitoring activities are defined within the QIS.

§1915(i) State plan HCBS
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4. Method for Evaluating Effectiveness of System Changes

HSD will contract with IQA to implement person centered planning, monitor outcomes, report compliance of contracted entities and collect data for use in the QIS strategy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Community First Choice State Plan Option

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

Community First Choice Option services are available to State plan eligible groups as described in Section 2.2-A of the State plan. These individuals are eligible for medical assistance under the State plan and are in an eligibility group that includes Nursing Facility services or are below 150% of federal poverty level if they are in an eligibility group that doesn't include Nursing Facility services.

The State, through the person-centered plan coordinator or state trained assessor will determine initially, and at least annually, that individuals require the level of care provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/ID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. Level of Care (LOC) for individuals under age 21 and 65 and over needing psychiatric services is determined using hospital level of care criteria. Different tools are utilized in order to accurately assess an individual's specific needs based on the institutional Level of Care being assessed.

The "Client Assessment and Planning System (CAPS)" is the tool used to establish nursing facility level of care. It is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The tool allows for identification of needs being met utilizing natural supports, state plan and waived services, thus allowing for a full and comprehensive assessment and service plan. The CAPS documents the level of need and calculates the individual's service priority level (in accordance with OAR chapter 411, division 015), calculates the service payment rates, and accommodates individual participation in service planning. Individuals are actively involved in the assessment process and will have the opportunity to identify goals, strengths and needs. They will be allowed to have anyone they would like to participate in the assessment process.

A standardized level of care assessment tool is used to determine whether an individual meets the institutional criteria for ICF/IDD. The LOC assessment ensures that the impairments indicated are explicitly related to eligibility and meets the criteria for a significant impairment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Community First Choice State Plan Option

The tool uses information regarding the individual's qualifying diagnosis, and may include IQ and adaptive impairment scores based on an assessment of functional areas to make the determination.

Once approved, the person-centered plan coordinator must review the individual's service needs at least annually and more frequently if the individual's functional needs change or if requested by the individual. The date of review is required, indicating that the review has been completed and the individual continues to meet the Level of Care criteria. A case note of this will also be made to the individual's case management file.

All individuals considered for the Hospital Level of Care are assessed using the Level of Care assessment form and MFCU clinical criteria. The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation. The Clinical Criteria tool assesses and scores various care elements that the assessor expects to last six months or more. It measures nursing and other intervention needs, factoring in frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular. Individuals must have a physician's signature that hospital level of care is required.

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based waived service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration but will not be allowed to receive duplicative services in CFC or any other available community-based services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Community First Choice State Plan Option

For Individuals eligible under section 1902(a) (10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, excess income determined under 42 C.F.R. 435.726 is applied, in addition to the cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The LOC assessment is just one step in the planning process. Another step is the functional needs assessment that identifies the needs of the individual that must be addressed to ensure their safety and well-being and to ensure that individuals do not become unnecessarily institutionalized. The person-centered service plan (PCSP) that is individualized to address the individual's strengths, supports, goals and ensures their independence, dignity and well-being, is also completed.

ii. Service Delivery Models

Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

Direct Cash

Vouchers

Financial Management Services in accordance with 441.545(b) (1).

Other Service Delivery Model as described below:

iii. Service Package

A. The following are included CFC services (including service limitations):

Attendant services and supports assist in accomplishing activities of daily living, instrumental activities of daily living and health related tasks through hands-on assistance, supervision, or cueing.

Services may be provided in the individual's home through enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community programs/settings of their choice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Community First Choice State Plan Option

Programs/settings meet the home and community-based criteria in 441.530. The service providers are all existing provider types in Oregon's service delivery system.

1. Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing.

The State will cover services and supports related to core activities of daily living including: assistance with bathing/personal hygiene, dressing, eating, mobility (ambulation, transferring and positioning), bowel care and bladder care, stand-by support, cognition, memory care and behavior supports.

Hands-on assistance, supervision, and/or cueing is defined as:

- "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.
- "Hands-on" means a provider physically performs all or part of an activity because the individual is unable to do so.
- "Monitoring" means a provider must observe the individual to determine if intervention is needed.
- "Redirection" means to divert the individual to another more appropriate activity.
- "Set-up" means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.
- "Stand-by" means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.
- "Support" means to enhance the environment to enable the individual to be as independent as possible.
- "Memory care support" includes services related to observing behaviors, supervision, and intervening as appropriate in order to safeguard the service recipient against injury, hazard or accident. These specific supports are designed to support individuals with cognitive impairments.

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The State will cover IADL supports including light housekeeping, laundry, medication management, meal preparation, shopping, and chore services.

- Chore Services are not housekeeping and are not included in the “Service supports” listed above. These services are intended to ensure that the individual’s home is safe and allows for independent living. Specific services include heavy cleaning to remove hazardous debris or dirt in the home and yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

ADL and IADL supports will be provided by enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community setting of the individual’s choice.

The state will provide Long-term Care Community Nursing Services (LTCCNS) to support health related tasks within the state’s nurse practice act. These services include nurse delegation and care coordination for eligible individuals. This service does not include direct nursing care and the services are not covered by other Medicaid spending authorities.

“Delegation means that a Registered Nurse authorizes an unlicensed person to perform a task of a nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and re-evaluating the task at regular intervals.” These services are designed to assist the individual and care provider in maximizing the individual's health status and ability to function at the highest possible level of independence in the least restrictive setting.

Services include:

- Evaluation and identification of supports that minimize health risks, while promoting the individual's autonomy and self-management of healthcare;
- Medication reviews;
- Collateral contact to the person-centered plan coordinator regarding the individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered service plan; and
- Delegation of nursing tasks, within the requirement of Oregon’s nurse practice act, to an individual’s caregivers so that caregivers can safely perform health related tasks.

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The following list identifies criteria that may lead to a referral for LTCCNS.

- Need for the eligible individual, family member or care provider education;
- Need for delegation of a nursing care task;
- Medication safety issues or concerns;
- Unexpected increased use of emergency care, physician visits or hospitalizations;
- Changes in behavior or cognition;
- Nutrition, weight, or dehydration issues;
- Pain Issues;
- History of recent, frequent falls;
- Potential for skin breakdown or recently resolved skin breakdown; and
- Eligible individual who does not follow medical advice.

Long-term Care Community Nurses also assist in providing safe and appropriate community care supports and managing chronic diseases. Services are specific addressing health related tasks and do not duplicate services provided through other state plan or waiver authorities. LTCCNS provide person-centered plan coordinators, care providers and health professionals with information that they need to maintain the individual's health, safety, and community living situation while honoring their autonomy and choices {OAR 411-048-0150 (2)(a)}.

The LTCCN services may be delivered by the following enrolled Medicaid providers:

- An licensed Registered Nurse (RN) who is a self-employed provider;
- Licensed Home Health agencies; or
- Licensed In-Home agencies.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

Services include functional skills trainings, coaching, and prompting the individual to accomplish the ADL, IADL and health-related skills. Services will be specifically tied to the functional needs assessment and person-centered service plan and are a means to increase independence, preserve functioning, and reduce dependency of the service recipient.

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A worker may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the individual service plan;
- The activities are for the sole benefit of the individual and are only provided to the individual receiving CFC services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition;
- The activities are provided consistent with the stated preferences and outcomes in the individual support plan;
- The activities are provided concurrent with the performance of ADL, IADL, and health related tasks as described in the earlier section;
- Training and skill maintenance activities that involve the management of behavior during the training of skills, must use positive reinforcement techniques; and
- The provider must receive training about appropriate techniques for skill training and maintenance activities.

Skill training and maintenance activities do not include therapy or nursing services that must be performed by a licensed therapist or nurse, and are otherwise covered under the state plan, but may be used to complement therapy or nursing goals when authorized and coordinated through the person-centered service plan.

The majority of these services will be provided by state authorized skills trainers or programs who have demonstrated expertise in assisting individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living and instrumental activities of daily living.

Long-term Care Community Nursing Services are also in this category of services. LTCCNS nurses, within the scope of the state's nurse practice act requirements, assist individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish health related tasks. Community nurses are licensed registered nurses with the expertise to provide these skills.

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- 3. Back-up systems or mechanisms to ensure continuity of services and supports.** The state will cover back-up systems and mechanisms to ensure the continuity of services and supports and the safety and well-being of the individual. These systems and mechanisms include:
- Electronic back-up systems:
 - Emergency Response Systems provide back-up for individuals who live alone or are alone for significant periods of time in their own homes.
 - Electronic devices to secure help in emergency for safety in the community and other reminders that will help an individual with activities such as medication management, eating or other monitoring activities.
 - Examples of electronic devices include Personal Emergency Response Systems, medication minders, and alert systems (for meal preparation, ADL and IADL supports that increase an individual's independence). Mobile electronic devices and other assistive technology will be reviewed on a case-by-case basis to determine cost-effectiveness and the ability to replace human interventions as identified in the person-centered service plan. Reviews will be conducted by the person-centered plan coordinator. Expenditures over \$1200 per year must receive prior approval from the DHS policy office.
 - Assistive Technology provides additional security to individuals and replaces the need for direct interventions. Assistive Technology also allows the individual to self-direct their care and maximizes independence.
 - Examples of assistive technology include, but are not limited to, motion and sound sensors, two-way communication systems, automatic faucet and soap dispensers, toilet flush sensors, incontinent sensors and fall sensors.

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Coverage will be limited to devices and technology not covered by other Medicaid programs and will be limited to the least costly option necessary to meet the service recipient's assessed need. Electronic back-up systems are not available to individuals living in settings that are required to provide these back-up systems for their residents as part of licensing requirements.

Technology will be provided by Medicaid enrolled provider or the state's approved purchasing guideline.

Relief Care:

Person-centered plan coordinators assist with identifying a regularly-scheduled relief care provider as part of the service plan or have identified back-up providers or care setting alternatives as part of the PCSP in case the participant's primary provider becomes ill or is suddenly no longer available. Additionally, individuals may utilize alternate service providers such as contracted in-home care agencies that can be employed on short notice if an individual cannot locate a Homecare Worker or Personal Support Worker who can meet their needs. Other licensed community-based service providers may be used to meet immediate care needs when an individual is unable to find a suitable provider to employ directly. Individuals can utilize 24 hour, home and community-based settings (such as FH/AFH/ALF/RCF/GCH, etc.) if they are unable to locate an in-home provider to meet immediate care needs. Local, state or contracted case management entities have access to Medicaid approved provider information for the state to assist individuals in selecting a provider from anywhere in the state.

Positive Behavioral Support Services:

Positive Behavioral Support Services are provided to assist individuals with behavioral challenges due to their disability, that prevent them from accomplishing ADL's, IADL's, and health related tasks. Positive Behavioral Support Services include coaching and support of positive behaviors, behavior modification and intervention supports to allow individuals to develop, maintain and/or enhance skills to accomplish ADL's, IADLs and health related tasks. The need for these services is determined through a functional needs assessment and the individual's goals as identified in the person centered planning process. Positive Behavioral Support Services may also include consultation to the care provider on how to mitigate behavior that may place the individual's health and safety at risk and prevent institutionalization.

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Services may be implemented in the home and/or community, based on an individual's assessed needs. All activities must be for the direct benefit of the Medicaid beneficiary.

Behavior Professionals will work with the individual and, if applicable, the caregiver, to assess the environmental, social, and interpersonal factors influencing the person's behaviors. The consultants will develop, in collaboration with the individual and if applicable, caregivers, a specific positive behavioral support plan to address the needs of the person to acquire, maintain and enhance skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks. These services do not include rehabilitation or treatment of mental health conditions. The provision of this service will not supplant the provision of personal attendant services that are based on the individual's assessed needs that are identified in the PCSP. Positive Behavioral Support Services are prior authorized based on the approved PCSP. Services are provided through Behavior Professionals approved by the Department or designee.

4. Voluntary training on how to select, manage, and dismiss attendants. Please identify who is performing these activities.

Individuals will be offered the opportunity to participate in training on how to manage their attendant services. As an example, the Oregon Home Care Commission (HCC) provides a voluntary training called the STEPS program that promotes successful working relationships between consumer-employers and homecare workers or Personal Support Workers. STEPS is a voluntary program offered statewide through the local Centers for Independent Living, Area Agencies on Aging or other not-for-profit organizations with the expertise to train eligible individuals. Individuals are informed of the training during service planning and are provided with information about the local contractor in order to register. The HCC also contacts individuals directly to offer the voluntary training.

All individuals will be offered the opportunity to participate in the training. The training will be offered on either a one-on-one basis or in a group format, depending on which format will meet the needs of the particular eligible individual. The training program will cover selection, management and dismissal of homecare workers and personal support workers.

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Topics will be specific to the individual but include: understanding the Person-centered Service Plan and Task List/Service Agreement, creating job descriptions, locating employees, interviewing and completing reference checks, training, supervising and communicating effectively with employees, tracking authorized hours worked, recognizing, discussing and attempting to correct any employee performance deficiencies, discharging unsatisfactory workers, and developing a back-up plan for coverage of services.

5. Support System Activities

The local, state or contracted case management entities, primarily through person-centered plan coordinators and state trained assessors, provide support system activities to individuals enrolled in CFC option. The activities provided by these entities include:

Assessment and counseling prior to enrollment in CFCO:

- i. Information, counseling, training and assistance to ensure that an individual is able to manage the services.
- ii. Information communicated to the individual in a manner and language understandable by the individual, including needed auxiliary aids and/or translation services.
- iii. Support activities include the following:
 - i. Conducting person-centered planning
 - ii. Range and scope of available choices and options
 - iii. Process for changing the person-centered service plan
 - iv. Grievance process
 - v. Risks and responsibilities of self-direction.
 - vi. Free Choice of Providers
 - vii. Individual rights and appeal rights.
 - viii. Reassessment and review schedules
 - ix. Defining goals needs and preferences
 - x. Identifying and accessing services, supports and resources.

TN 18-0004

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- xi. Development of risk management agreements.
- xii. Development of personalized backup plan.
- xiii. Recognizing and reporting critical events, including abuse investigations.
- xiv. Information about advocates or advocacy systems and how to access advocates and advocacy systems.

Conflict of Interest Standards

The State assures that conflict of interest standards for the functional needs assessment and development of the person-centered service plan applies to all individuals and entities, both public and private. Oregon's Conflict of Interest Standards require an individual to publicly declare when a potential conflict of interest arises, prior to taking any action on behalf of the public. A public declaration describing the nature of the conflict is required if an actual conflict of interest has occurred. The State will ensure that the individuals conducting the functional needs assessment and person-centered service plan are not:

- 1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.
- 2) Financially responsible for the individual.
- 3) Empowered to make financial or health-related decisions on behalf of the individual.
- 4) Individuals who would benefit financially from the provision of assessed needs and services.
- 5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual.

Risk Management Plans

A risk assessment is conducted, in-person, for all individuals during the person-centered planning process. A risk management plan is developed for each individual and is detailed in the service plan. Person-centered plan coordinators must conduct risk assessments on an annual basis and the monitoring frequency as based on the level of risk determined during the assessment process. Person-centered plan coordinators use a risk assessment tools to determine the level of risk based on multiple risk factors: power outage/natural disasters, physical functioning, mental/emotional functioning, cognitive functioning, behavioral issues, income/financial issues, safety/cleanliness of the residence, whether the service plan meets the needs of the individual, the adequacy and availability of natural supports, and access to services.

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All individuals receiving services will be contacted at least quarterly throughout the year (minimum of 1 contact every three months). Individuals with three or more high risk factors must be contacted at least monthly. One of the contacts must be face-to-face while others may occur either by phone or other interactive methods, examples include but are not limited to, email or other secure methods, depending on the individual's preference and abilities.

The Department requires criminal background checks as a provider qualification and utilizes these background checks as a risk management tool. The Department assumes the cost of the background checks.

B. The State elects to include the following CFC permissible service(s):

1. X Expenditures relating to a need identified in an individual's person-centered plan of services that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance. These include:

Environmental Modifications. Environmental modifications are provided in accordance with 441.520(b).

Assistive Devices. Assistive Devices means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living or instrumental activity of daily living. Coverage will be limited to devices and technology not covered by other programs and will be limited to \$5000 per device or assistance based on an assessed need of the service recipient. Person-centered plan coordinators may request approval for additional expenditures through the DHS policy office prior to expenditure. Expenditures will only be made for the most cost effective device or assistance and must be approved by the Department for any expenditure over \$1200.

Community Transportation. Community Transportation is provided to eligible individual to gain access to community-based state plan and waiver services, activities and resources. Trips are related to recipient service plan needs, are not covered in the 1115 medical benefit, are not for the benefit of others in the household, and are provided in the most cost-effective manner that will meet needs specified on the plan. Community Transportation services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individual; 2) compensate the service provider for travel to or from the service provider's home.

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Home-Delivered Meals (HDM). HDMs are provided for participants who live in their own homes, are home-bound, are unable to do meal preparation, and do not have another person available for meal preparation. Payment for HDMs will not be allowed when individuals are receiving CFC services in a setting where residential providers must provide meals. Home and community based residential providers must provide meal services. Provision of the home delivered meal reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner. Each HDM contributes an estimated one-third of the recommended daily nutritional regimen, with appropriate adjustments for weight and age. HDM providers bill the state Medicaid program directly for no more than two meals per day.

2. X Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides. These expenditures are limited to individuals transitioning from a nursing facility, IMD, or an ICF/ID to a home or community-based setting where the individual resides.

Service Limits

Service levels for home and community-based services and allowable activities for in-home services are based on the individualized functional assessment of service needs. In-Home hourly allocation may be divided between support for ADLs, IADLs, and Health-Related Tasks. The following items will be based on the individual's functional assessment and identified as being unmet by other state plan services or natural supports:

- Assistance with Activities of Daily Living (ambulation, transferring, eating, cognition /behaviors, dressing, grooming, bathing, and hygiene), and
- Instrumental Activities of Daily Living (housekeeping, laundry, medication management, transportation, meal preparation, and shopping).

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Natural supports are identified during the person centered service planning process and utilized when available to the individual. Natural Supports are defined as resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Natural supports are determined to be available when an individual listed above is willing to voluntarily provide the identified services and the service recipient is willing to accept services from the natural support. If the natural support is unwilling or unable to provide the identified services, paid supports will be provided. This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan. Nothing in the natural support determination prevents the Department from paying qualified family members who are performing paid work. The state will not provide services or supports that are within the range of activities that a parent/legally responsible individual would ordinarily perform on behalf of a child without a disability or chronic illness of the same age.

Payment for home-delivered meals, chore services, home-care workers or personal support workers, personal emergency response systems, relief care providers, and environmental accessibility adaptations will not be allowed when they would duplicate other services provided under another benefit or program. Home and community based residential providers must ensure their residents have access to substantially similar services as those living in their own homes. Department contracted Community Nurses will provide services for individuals living in their own homes or Foster Homes. Payment for LTCCNS will not be allowed when individuals are receiving CFC services in other residential home and community based settings.

Health related tasks will be limited to a need or needs, identified through the functional assessment and reflected in the person-centered service plan.

Electronic back-up systems, mechanisms and any specialized or durable medical equipment necessary to support the individual's health or well-being will be limited to items approved in the services plan and are not to exceed \$5,000 and payable only when other funding authorities such as Medicare, Medicaid or private insurance, disallow the item or service. Person-centered plan coordinators may request approval for expenditures beyond the limit through the DHS policy office prior to expenditure. Services must be the most cost-effective and approved by the Department.

Transition services will be limited to necessary services for individuals transitioning from an institution into a community-based or in-home program. Services will be based on an assessed need, determined during the person-centered service planning process and will support the desires and goals of the individual receiving services and supports. Final approval for expenditures will be through the DHS policy office prior to expenditure.

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Approval will be based on individual's need and the policy office's determination of appropriateness and cost-effectiveness. Financial assistance will be limited to: moving and move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishing (i.e. bed) and other items necessary to re-establish a home. Individuals will be able to access the benefit no more than twice annually though basic household furnishing and other items will be limited to one time per year.

Environmental modifications are limited to \$5,000 per modification. Person-centered plan coordinators may request approval for additional expenditures through the DHS policy office prior to expenditure. Approval will be based on individual's need and goals and the policy office's determination of appropriateness and cost-effectiveness. Environmental modifications must be tied to supporting ADLs, IADLs and health-related tasks as identified in the service plan. Modifications over \$500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made within the existing square footage of the residence, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

All services are expected to be provided in a person centered manner with a focus on including the eligible individual and promoting self-management of the health condition(s) whenever possible.

Exceptions to limits and service payments may be requested but will only be granted if DHS determines:

- (a) The individual has service needs, documented in the service plan, that warrant an exception for hours or payment; and
- (b) No alternative, in the least restrictive setting possible, is available to meet the needs of the individual.

Distinct service elements, procedure codes and claim modifiers will differentiate whether the services are State Plan K services or other Medicaid Services under 1915 (c) or other authorities. This will ensure that there is no duplication of services.

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iv. Use of Direct Cash Payments

- a) The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- b) The State elects not to disburse cash prospectively to CFCO participants.

v. Assurances

- (A) The State assures that any individual meeting the eligibility criteria for CFCO will receive CFC services.
- (B) The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid program..
- (C) The State assures the provision of eligible individual controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.
- (D) With respect to expenditures during the first full 12 months in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding 12month period.
- (E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.

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(F) The State assures the collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a CFC the choice to instead receive home and community-based services in lieu of institutional care.

(G) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

- (i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.
- (ii) The number of individuals that received such services and supports during the preceding fiscal year.
- (iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
- (iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a CFC.

(H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws consistent with 441.570(d)(1)-(5).

(I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of eligible individuals who are individuals with disabilities, elderly individuals and their representatives.

vi. Assessment and Service Plan

Level of Care assessments and functional needs assessments will occur prior to the development of the service plan. Person-centered plan coordinators or state trained assessors complete a functional needs assessment, which includes a comprehensive discussion with the participant about the participant's functional abilities and strengths in completing activities of daily living and instrumental activities of daily living. Individuals will be actively involved in the functional needs assessment process and will have the opportunity to identify goals, strengths and needs.

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They will be allowed to have anyone they would like participate in the assessment process. Person-centered plan coordinators will also discuss psycho-social elements and the availability of natural supports to assist in meeting needs. The Department uses assessment tools that measure individual needs surrounding ADLs and IADLs along with cognitive/behavior concerns. The assessment records individual needs and preferences regarding the individual's choice of how the services are to be provided, regardless of what funding mechanisms or supports are intended to meet the individual's needs.

All level of care assessments and reevaluations are conducted by person-centered plan coordinators or state trained assessors. DHS' minimum person-centered plan coordinators qualifications and state trained assessors' qualifications are:

- Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; OR
- Bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); OR
- Associate's degree in a Behavioral Science, Social Science or a closely related field AND two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); OR
- Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economically disadvantaged , employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing);
- In addition to the above, state trained assessors responsible for completing assessments must meet initial and ongoing training requirements provided by DHS.

To meet Nursing Facility LOC, individuals must be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010 to meet the nursing facility level of care criteria:

- (1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.
- (2) Requires Full Assistance in Mobility, Eating, and Cognition.

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- (3) Requires Full Assistance in Mobility, or Cognition, or Eating.
- (4) Requires Full Assistance in Elimination.
- (5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.
- (6) Requires Substantial Assistance with Mobility and Assistance with Eating.
- (7) Requires Substantial Assistance with Mobility and Assistance with Elimination.
- (8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.
- (9) Requires Assistance with Eating and Elimination.
- (10) Requires Substantial Assistance with Mobility.
- (11) Requires Minimal Assistance with Mobility and Assistance with Elimination.
- (12) Requires Minimal Assistance with Mobility and Assistance with Eating.
- (13) Requires Assistance with Elimination.

Levels are determined as a result of a comprehensive assessment, conducted by a person-centered plan coordinator, using an electronic tool called the Client Assessment and Planning System (CAPS). This assessment documents a person's abilities and limitations in areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments and general health history. Using a programmed algorithm, CAPS then calculates an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. This assessment tool is used to determine Level of Care for both home and community based care and nursing facility care.

Children being assessed for NF LOC are assessed using the Medically Involved Clinical Criteria tool as defined in OAR 411-300-0020. The clinical criteria tool scores based on needs for the child that are outside of the school setting. The assessment factors in age appropriate care needs when reviewing ADL and IADL abilities and limitations. The tool also factors in paramedical interventions that may be needed. These are areas that require physician's orders or RN delegation. The assessment scores points based on the intensity of assistance needed and severity and intensity of medical interventions.

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In order to meet the ICF/ID level of care, an individual must meet eligibility criteria as described in OAR 411-320-0080 for intellectual disability or developmental disability other than intellectual disability and have significant impairment in adaptive behavior. State trained assessors complete the initial LOC assessment. State trained assessors or person centered plan coordinators review the level of care annually, or more frequently based on the functional needs of the individual, or at the request of the eligible individual. The assessments happen during a face-to-face meeting with the individual. The state trained assessor or person-centered plan coordinator completes the assessment using personal observations of the individual, interviews with the individual and others with personal knowledge of the individual, and documentation of the individual's functioning from information in the individual's file, such as standardized tests administered by qualified professionals.

Once the state trained assessor completes the initial LOC they submit it to DHS.

DHS employs a Diagnosis and Evaluation Coordinator (D & E Coordinator), to assist with oversight and training person-centered plan Coordinators.

A component part of the LOC assessment is to confirm:

That the individual meets eligibility criteria of a person with an intellectual with an intellectual disability or a closely related condition as well as functional impairments as a result of the condition. The determination is based on the diagnosis and functional impairments (whether the individual has substantial limitations in the six areas of major life activity identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living").

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The Department uses a LOC tool that indicates impairments are explicitly related to eligibility. Additionally, eligibility specialists sign an attestation verifying the eligibility as intellectually disabled or developmentally disabled under OAR 411-320-0080. The diagnostic area will include additional information regarding the individual's qualifying diagnosis, and IQ and adaptive impairment scores used to make the determination.

All individuals considered for the Hospital Level of Care are assessed using the Level of Care assessment form and MFCU clinical criteria. The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation. The Clinical Criteria tool assesses and scores various care elements that the assessor expects to last six months or more. It measures nursing and other intervention needs, factoring in frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular. Individuals must have a physician's signature that hospital level of care is required.

Person-Centered Service Plan Requirements:

The person-centered service plan will reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. The plan must:

- (1) Reflect that the setting in which the individual resides is chosen by the individual.
- (2) Reflect the individual's strengths and preferences.
- (3) Reflect clinical and support needs as identified through an assessment of functional need.
- (4) Include individually identified goals and desired outcomes.
- (5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.

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(Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual.) This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan.

(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans.

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.

(8) Identify the individual and/or entity responsible for monitoring the plan.

(9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation. E-signature will be used when a written signature is not possible.

Person-Centered Service Plan Development Process: Local, state or contracted case management entities have the responsibility for determining the individual's level of care, performing a functional needs assessment and developing a person-centered service plan in accordance with the individual's choice of services to be provided. The service planning process includes evaluating all available resources and funding mechanisms to meet the individual's needs. A primary goal is to develop a person-centered service plan that identifies strengths, desires, goals and existing supports and to develop a comprehensive plan that honors the dignity, strength and autonomy of the individual and that supports their right to be as integrated in the community as they choose.

The individual or designated representative decides who may or may not be included in person-centered service plan development discussions and contribute to the individual's person-centered service plan. Person-centered plan coordinators assist the individual in selecting and notifying other participants in the assessment and planning process. Person-centered plan coordinators meet with each individual (and family or representative, as appropriate) on a schedule that assures eligibility determinations and assessments are completed within 45 days of request of services.

The person-centered plan coordinator must address the needs of the participant through the PCSP and provide the participant a copy of the plan. The eligible individual will have the opportunity to review and modify the plan. The person-centered plan coordinator will work with the individual to identify the individual's goals, needs and preferences for the way that services are provided and received. Local, state or contracted case management entities give individuals information about the array of options available to them and provide choice counseling. The person-centered plan coordinator will ensure that providers have a copy of the relevant tasks from the service plan for which they are responsible.

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The person-centered plan coordinator will consult with service providers and the individual throughout the assessment process to review and verify the appropriate services are being offered, performed and are still appropriate for the individual. This ongoing dialogue will ensure that any changes in condition or service choice allow for the assessment to be reviewed for appropriateness as quickly as possible. Local, state or contracted case management entities inform participants/ representatives about service options at changes in conditions and when the participant is transitioning from one care-setting to another.

Local, state or contracted case management entities assist with health care coordination and may make referrals to contracted LTCCNS Nurses, including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. The state will provide Long-term Care Community Nursing Services (LTCCNS) to support health related tasks within the state's nurse practice act. These services include nurse delegation and care coordination for eligible individuals. This service does not include direct nursing care and the services are not covered by other Medicaid spending authorities. All other licensed providers must have nursing staff available for delegation, teaching and training.

Each plan will address the eligible individual's choice for the type of services they receive, the service provider and location of the service delivery. Choice is a critical aspect in the person-centered service plan.

Each plan includes the type of service to be provided, the amount, frequency and duration of each service, and the type of provider to furnish each service. Since the plan is built in conjunction with the assessment of needs, it may be developed simultaneously with determination of level of care and eligibility for CFC services or shortly after, allowing time for researching and reviewing available natural supports, providers and service options.

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An in-home service plan is implemented when a qualified provider is identified, the qualified provider's service start date is set and the authorized hours of services are determined. A plan for facility services is implemented as soon as the individual chooses and moves into a community-based facility. The individual has the right to request changes in qualified provider and living situation. A change in plan will be implemented as soon as an alternate plan can be developed. Person-centered plan coordinators will meet with the individual (and family or representative, as appropriate) at least annually to review and update the PCSP.

Local, state or contracted case management entities coordinate services for participants who reside in facilities in cooperation with facility staff at the direction of the individual. The person-centered plan coordinator communicates with facility staff on a regular basis and may participate in facility care conferences. These care conferences are distinct from the functional assessment, person-centered plan development process and other direct communication with the individual and their representative.

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Person-centered plan coordinators inquire and identify risks such as environmental hazards that may jeopardize safety or health. For participants living at home or in some foster homes, person-centered plan coordinators gather information about emergency plans in the event of a natural disaster. Administrative Rules require Community-Based facility providers to prepare emergency plans for response to natural disasters.

The State assures that conflict of interest standards for the functional needs assessment and development of the person-centered service plan applies to all individuals and entities, both public and private. The State will ensure that the individuals conducting the functional needs assessment and person-centered service plan do not have a conflict of interest.

vii. Home and Community-based Settings

CFC Services will be provided in a home or community setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental diseases, or an intermediate care facility for the intellectually disabled. Settings will include the individual's home or in the community. Licensed, Certified or Endorsed Community-based settings include-

- Assisted Living Facility (ALF)
- Adult Foster Care (AFC)
- Adult Day Center
- Day Habilitation Provider
- Residential Care Facilities (RCF)
- Residential Treatment Facility/Home for Mentally or Emotionally Disturbed Persons
- Supported Living Providers
- Adult Group Home (GCH)
- Group Care Homes for Children (GCH)
- Developmental Disabilities Adult Foster Care
- Children's Developmental Disability Foster Care
- Children's Developmental Disability Host Home
- Acute Care Hospital

Licensed or certified community-based settings maintain the following characteristics:

- a. The setting is integrated in and facilitates the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities.**

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Individuals will have the ability to choose from services in their own home, a family home, or in a licensed setting. By statute, all licensed settings are integrated into communities. Individuals can also choose to receive services in an acute care hospital as long as the services are identified in the individual's person-centered service plan, address needs that are not met through the provision of hospital services, are not duplicative of services the hospital is obligated to provide and are designed to ensure smooth transitions between acute care settings and home and community-based settings while preserving the individual's functional abilities. Individuals have the ability to fully engage in their community including engaging in any community activity such as seeking/retaining employment, social activities, religious services and community events. Providers in licensed settings are to provide or arrange for transportation if the individual cannot. Individuals retain control over their personal resources unless they have chosen not to or have been determined by the courts or the Social Security Administration to be unable to manage their personal resources.

Through regular visits with the individual, occurring no less frequently than annually, person-centered plan coordinators ensure that individuals have access to the greater community and have the opportunity to engage in community life and control their own resources. Licensing staff ensure compliance with statutes, regulations and rules that ensure that providers do not impinge on the liberties of the individuals residing in the facility. OAR specifies services that must be provided for residents. Additionally, residents receiving CFC services in CBC residential settings all have resident rights and protection under Oregon Revised Statute Chapter 443.

Oregon statute allows for the State to determine the location of residential facilities: Siting of licensed residential facilities. (1) To prevent the perpetuation of segregated housing patterns, the Department of Human Services, in consultation with the Oregon Health Authority, shall determine the location and type of licensed residential facilities and the location of facilities.

b. The setting is selected by the individual from among all available alternatives and is identified in the person-centered service plan;

While developing the service plan for each individual, the person-centered plan coordinators fully informs individuals of all of the many choices that are available to them. If an individual chooses a licensed setting, the person-centered plan coordinator provides information about each of the licensed settings available to the individual. Individuals may review and tour as many settings as they would like anywhere in the state. The individual selects the provider of their choice. Person-centered plan coordinators enter the choice into the person-centered service plan.

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- c. **An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;**
- d. **Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented**

For both c. and d. above, all Community Based Care Residential Providers are required by Oregon Revised Statute (ORS) and Oregon Administrative Rules (OARs) to comply with and post in a prominent location the Resident Bill of Rights. The Resident Bill of Rights in each setting ensure, at a minimum, privacy in their personal interactions and communications, dignity, respect, personal choice, rights to grieve without fear of retaliation, and freedom of abuse, neglect and discrimination.

OARs provide that restraints can only be used in the case of an emergency to protect the individual or other individuals and defines abuse which may include involuntary seclusion and wrongful restraint. Neither seclusion nor restraint may be used for discipline or convenience of the provider and must be part of a defined plan to address the safety of the individual or other residents.

- e. **Individual choice regarding services and supports, and who provides them, is facilitated.**

Individuals have full choice regarding the services and supports they receive and who provides those services. Person-centered plan coordinators have access to a full range of qualified providers which they share with the individual. Person-centered plan coordinators assist individuals in locating appropriate providers. Person-centered plan coordinators also assist individuals in identifying and mitigating risks associated with the individual's choice. Frequent site reviews monitor compliance with this expectation.

- 1. **The unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the State's landlord tenant law of the State, county, city or other designated entity.**

Individuals living in licensed care settings have rights substantially similar to individuals renting their own apartment or house.

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In the majority of situations providers may not transfer or move out an individual without 30 days written notice. An individual may only be asked to leave involuntarily for medical reasons, or for the welfare of the resident or other residents, or for nonpayment. Each individual has an opportunity for a hearing. A licensee may give less than 30 calendar days' notice ONLY if undue delay in moving the resident would jeopardize the health, safety, or well-being of the resident, the resident exhibits behaviors that pose an immediate danger to self or others, or the resident is hospitalized or is temporarily out of home and the provider determines that they will not be able to meet the needs of the individual when they return.

2. Each individual has privacy in their sleeping or living unit:

Individuals have privacy in their living and/or sleeping unit unless the person-centered service plan identifies a risk to such privacy (i.e., severe self-injurious behaviors or uncontrolled seizures.). Individuals have the ability to furnish their sleeping or living unit. The goal is to serve people in the most home-like setting possible based on their person-centered service plan, rather than traditional congregate settings. Some settings may have individual bathrooms attached to the living or sleeping unit, and others may not. Individuals, whose person-centered service plan does not indicate risks, will be able to choose from all available options including those with lower and higher levels of privacy. The critical choice occurs before an individual chooses a specific setting. If privacy, such as an individual bathroom attached to the living unit is important to the individual, they will select a provider that offers such amenities. Person-centered plan coordinators will assist individuals in locating a provider that meets their particular needs and wants.

Foster Homes and RCFs are home-like settings that may or may not have the highest level of privacy since the fundamental concept is to model traditional family homes as much as possible. ALFs have the highest level of privacy available with private bathrooms. Regardless, individuals have the right to privacy in all settings and the inherent dignity and respect will be honored. A primary driver is to ensure that individuals have as much control over their life as possible.

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3. Units have lockable entrance doors, with appropriate staff having keys to doors;

The goal is to serve people in the most home-like setting possible rather than traditional congregate settings. Individuals, whose person-centered service plan does not indicate risks, will be able to choose from all available options including those with locks on the living or sleeping units. The critical choice occurs before an individual chooses a specific setting. If locked living or sleeping units are important to the individual, they will select a provider that offers locks. Person-centered plan coordinators will assist individuals in locating a provider that meets their particular needs and wants.

Foster Homes and RCFs are home-like settings that may or may not have locks on bedroom doors. ALFs have locking units with appropriate staff having keys. Regardless of locks, individuals have the right to privacy. If an individual would like a lock on their unit, and their person-centered plan does not indicate that this would endanger the individual, the request will be honored.

4. Individuals share units only at the individual's choice;

Some of the community-based care settings have two person rooms. An individual is made fully aware of this before they select that particular provider or setting. Assisted Living Facilities provide self-contained, individual living units in which each resident has full choice of living alone or with a roommate and whom that roommate is. Individuals have free choice in the type of setting and the specific provider they want to choose to deliver their services. Individuals in shared living settings, such as some RCFs and Foster Homes, always get to choose if they would like to have a roommate or choose a setting and provider in which they can have their own bedroom or share. The individual always has other options available to them. Person-centered plan coordinators will assist individuals in locating a provider that meets their particular needs and wants.

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5. Individuals have the freedom to furnish and decorate their sleeping or living units.

All community based care facilities create environments that are as home-like as possible. This includes the ability of the individual to decorate and furnish their bedrooms and/or living units. The only limitations allowed are limitations to protect the individual from health and safety standards, protect the integrity of the building structure, or the safety of other residents.

6. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

Individuals have full access to and the ability to participate in activities of social, religious, and community groups. Meals are usually addressed on a facility by facility basis though residents have access to food whenever they choose except when contraindicated by their specific condition (such as those with Pica). Limits are defined in the person-centered plan. Snacks are available upon request. Individuals may have their own food and eat whenever they choose. Food must be stored safely.

Facilities must provide diets that are appropriate to residents' needs and choices. The facility must encourage residents' involvement in developing menus. Menus must be prepared at least one week in advance, and must be made available to all residents. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. Individuals will have access to appropriate snacks provided by the facility. Individuals who would like other food may have access to their own food unless this causes a safety risk for themselves or other residents.

Resident Bill of Rights requires freedom to participate and choose social activities. Community based care residential provider types are required to facilitate and provide activities for which individuals can choose to participate. Individuals, whose person-centered service plan does not indicate a need for restrictions, can leave at any time to access the community.

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Person-centered plan coordinators work with the individual to ensure that their freedom and choices are being honored.

7. Individuals are able to have visitors of their choosing at any time;

Individuals have the ability to choose their visitors and when their visitors come to see them. Individuals may choose when their visitors are allowed to visit. Providers may discuss social covenants about the timelines to minimize disruption and negative impacts to other residents. Regardless, of these social covenants, providers must not limit visitors for their convenience.

Individuals are encouraged to maintain the maximum level of control possible while acknowledging that the individuals are sharing living space with other individuals. Restrictions must not be for the convenience of the provider and must be in the best interest of all residents or based on necessary restrictions identified in the person-centered plan. Facilities may limit access to visitors who are disruptive, violent or have a history of committing illegal activities.

8. The setting is physically accessible to the individual.

All facilities must be physically accessible to the individuals they serve.

Provider owned or controlled residential settings are not:

- a. Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.
- b. Located in a building on the grounds of or immediately adjacent to a public institution
- c. Located in a building on the grounds of or immediately adjacent to disability-specific housing.

The state will follow approved Statewide Settings Transition Plan. Oregon assures that the setting transition plan included with this 1915(k) State Plan Amendment will be subject to any provisions or requirements in the State's approved Statewide Settings Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Settings Transition Plan and will make conforming changes to its 1915(k) State Plan Amendment, as needed, when it submits the next amendment. The most recent version of the Statewide Settings Transition Plan can be found at:

<http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/Transition-Plan.aspx>

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viii. Qualifications of Providers of CFCO Services

Adult Day Providers- Licensing and certification requirements are OAR 411-066-0000 through 411-066-0015. Adult Day Service (ADS) programs that contract with the Department to provide services must be certified.

Adult Foster Care- Licensing requirements at OAR 411-050-0600 – 0690 OAR 309-040-0030 through 309-040-0330; and 411-360-0010 through 411-360-0310. Local CDDPs, Branch offices, DHS Central Office, and OHA/HSD are responsible for verification of provider qualifications upon initial license and annual renewal.

Adult Group Home- Contracted and State Operated Licensing requirements at OAR 411-325-0010 through 411-325-0480 and agency certification requirements at OAR 411-323-0010 through 411-323-0070. DHS Central Office is responsible for verification of provider qualifications biennially.

Assisted Living Facility- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Behavior Support Service Providers- Behavior consultants are certified by the state or approved by a Department Designee. The Department is responsible for verification of provider qualifications initially and at least every 5 years.

Children's Developmental Disability Foster Care- Certification requirements at OAR 411-346-0100 through 411-346-0230 or 413-200-0300 through 413-200-0396. DHS, Office of Developmental Disabilities Services (ODDS) or Child.

Children's Developmental Disability Host Home—

Children's Developmental Disability Host Homes Programs are certified and endorsed by the state. DHS Central Office is responsible for verification of provider qualifications initially and biennially thereafter.

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Welfare, will determine compliance based on receipt of the completed application material, an investigation of information submitted, an inspection of the home, a completed home study and a personal interview with the provider. Certification requirements are reviewed biennially.

Community Nursing Services – Providers are enrolled Medicaid providers that are licensed registered nurses, licensed Home Health agencies; or Licensed In-Home agencies. Providers meet minimum requirements established in OARs including passing a criminal background check and having minimum direct care experience in LTC programs.

Community Living Supports Agency Provider- Providers are certified under OAR Chapter 411, Division 323 and endorsed to requirements described in OAR Chapter 411, Division 450. People providing direct services to a recipient must pass a Criminal History Check conducted by the state at a minimum of every two years. The agency must demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3)(d). DHS verifies the qualifications of the provider every 5 years. Additionally, the Department can review at any time for cause. These providers are authorized to provide ADL, IADL and health related tasks during the course of attendant care, skills training, and relief care supports.

Community Transition Service Providers- Provider requirements at OAR 461-155-0526 Branch offices are responsible for verification prior to authorizing service and payment **Community Transportation,**

Individual provider- Providers are enrolled Medicaid providers. Valid Oregon Driver's License is required. Individuals providing transportation must be at least 18 years of age, have a valid driver's license, a good driving record, and proof of insurance. People providing direct services to a recipient must pass a Criminal History Check conducted by the state. People providing direct services in the family home or working alone with a recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; display capacity to provide good care for the individual; and have the ability to communicate with the individual. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Community Transportation, Bus/Taxi- Transportation provided by common carriers, taxicab or bus will be in accordance with standards established for those entities.

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Community Transportation, Agency Provider- Licensing and certification requirements at OARs 411-325-0010 through 411-325-0480; ; 309-035-0100 through 309- 035-0190; OARs 309-041-0550 through 309-041-0830; 411-345-0010 through 411-345-0300; 411-360-0010 through 411-360-0310; 411-328-0550 through 411-328-830; 411-346-0100 through 411-346-0230; 411-450-0080. People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Developmental Disabilities Support Services Provider Organization- Providers are certified under OAR 411-323-0010 through 411-323-0070 and endorsed to requirements at OAR 411-340-0030, OAR 411-340-0040, OAR 411-340-0050, OAR 411-340-0070, OAR 411-340-0080, and OAR 411-340-0090, and OAR 411-340-0170. DHS verifies the qualifications of the provider at the time of the initial certification and every 5 years. Additionally, the department can review at any time for cause.

Group Care Homes for Children- Certification requirements at OAR 411.349-0000 through 411-3490020; 411-325-0010 through 411-325-0480; or 413-215-0000 through 413-215-0883. DHS Central Office is responsible for verification of provider qualifications biennially.

Habilitation Agency Provider - Providers are certified and endorsed under OARs 411-345-0000 through 411-345-0300 and OAR 411-323-0010 through 411-323-0070. People providing direct services in the family home or working alone with a recipient must pass a Criminal History Check conducted by the state at a minimum of every two years.

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Demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3) (d). DHS verifies the qualifications of the provider every 5 years. Additionally, the department or the can review at any time for cause. These providers are authorized to provide ADL, IADL and health related tasks during the course of community living and inclusion supports and alternative to employment services.

Home Care Worker- Certification requirements at OAR 411-031-0020 - 0050. Branch offices are responsible for verification of provider qualifications at initial authorization. Criminal background checks are conducted initially and every 2 years.

In-Home Care Agency- Licensing requirements at OAR 333-536-0000 through 0100 and OAR 411-030-0002 through 0090. DHS Central office is responsible for verification of provider qualifications upon the execution and renewal of contracts.

Personal Support Worker- Requirements for qualification at OAR 411-375-0020. The Department is responsible for verification of these provider qualifications. Criminal background checks are conducted initially and every 2 years. . Personal Support Workers providing transportation must also have a valid driver's license, a good driving record, and proof of insurance as verified by the CDDP, Brokerage, or the Department. A representative of the CDDP, brokerage, the Department or family will verify that the person can provide the care needed by the individual. The common law employer (employer of record) is responsible for informing and training regarding the specific care needs of the individual. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

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Local Transportation Authorities- DHS/Provider contract specifications. DHS Central Office is responsible for verification of provider qualifications upon execution of renewal of contracts. Contracts are renewed every 2 years.

Residential Care Facilities- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Residential Treatment Facility for Mentally or Emotionally Disturbed Persons- License Licensed by the Oregon Health Authority under OAR 309-035-0110. Licenses are renewed every two years.

Skills Trainers- are hired or monitored by licensed, certified or specialty programs including Adult Foster Care, Adult Group Homes, Assisted Living Facilities, Community Living Supports Providers, Developmental Disabilities Support Services Provider Organizations, Group Care Homes, Habilitation Agency Providers, In-home Care Agencies, In-Home Support Provider Agency, Residential Care Facilities, Residential Treatment Facilities/Homes Specialized Living Services and Supported Living Agency providers that have demonstrated expertise in serving the targeted individuals.

Specialized Living Services- Certification requirements at OAR 411-065-0000 through 0050. Branch offices are responsible for verification of provider qualifications prior to executing a contract and annually thereafter. These service providers are authorized to provide ADL, IADL and health related tasks as well as acquisition services.

Supported Living Agency Provider - Providers are certified and endorsed under OARs 411-328-0550 through 411-328-0830 and OAR 411-323-0010 through 411-323-007. People providing direct services in the recipient's home or working alone with a recipient must pass a criminal history check conducted by the state at a minimum of every two years. T The agency must demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3) (d). Provider qualifications must be rechecked every 5 years. Additionally, the department or the CDDP can review at any time for cause.

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ix. Quality Assurance and Improvement Plan

The DHS Quality Assurance Teams (QAT) and policy staff members review and monitor the accuracy and consistency of operational and administrative functions performed by all state and local contracted entities through an ongoing process. Within a two year time frame, all state and contracted entities are fully reviewed. State and contracted entities also develop management plans that support key quality strategies and to address areas of concern: such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, eligible individual satisfaction and cost effectiveness.

The process of evaluation involves Quality Assurance Team examination of a sample of participant cases through review of data stored in electronic databases, review of case files on-site, and individual interviews that include an assessment of eligible individual satisfaction.

The QA Team records findings using program specific standardized tools and issues a formal finding in a report to the state or contracted entity identifying trends in policy and rule application. The state or contracted entity must submit a plan of correction to DHS within 30 days of receipt of this report that addresses any issues found in the QA Team report. DHS then issues a final report to the state or contracted entity. The Quality Assurance team revisits the state or contracted entity to follow-up with the written corrective action plans to ensure compliance and remediation of any issues addressed in the final report.

The assessment methods used by the QA Team include file reviews, onsite reviews, interviews and assessments with individuals receiving services, and service plan reviews.

Oregon has implemented the National Core Indicators project. The project gives the Department information from eligible individual's perspectives about Developmental Disabilities services. Oregon has implemented a system (Aspen) allowing the Office of Licensing and Regulatory Oversight increased access to information for licensing and quality assurance activities.

The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) is an internal leadership and governance body of OHA and DHS, chartered in accordance with the Inter-Agency Agreement (IAA). MOCSC is co-chaired by representatives of OHA and DHS appointed by the OHA/DHS Joint Operations Steering Committee (JOSC).

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The MOCSC provides high level oversight and decision-making on the operations of the Medicaid/CHIP programs and monitors the interagency agreements between DHS and OHA about Medicaid/CHIP program operations and their administrative issues.

Roles of the MOCSC include, but are not limited to:

- Providing high level oversight and decision-making on the operations of the Medicaid/CHIP programs;
- Ensuring the objectives of the interagency agreements between DHS and OHA about Medicaid/CHIP program operations and their administrative issues are being met;
- Ensuring that members fully discuss Medicaid/CHIP business and fiscal and operations issues that require decisions and resolution;
- Providing a high-level forum for the regular exchange of information on Medicaid/CHIP operations.
- Providing recommendations to the JOSC or the Medicaid/CHIP Policy Steering Committee/Joint Policy Steering Committee (JPSC) that link the business objectives of OHA and DHS (and the joint administrative processes applicable to Medicaid/CHIP programs operational and business processes) and may significantly affect both agencies
- Providing timely access, as needed by committees or workgroups, to review and recommend necessary actions, including an expedited review and decision-making process to accommodate time lines; and
- Referring concerns or disagreements related to decisions by the MOCSC to JOSC or JPSC as appropriate.

The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

The SPA application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- ◆ **Participant Access:** *Individuals have access to home and community-based services and supports in their communities.*
- ◆ **Participant-Centered Service Planning and Delivery:** *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*

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- ◆ **Provider Capacity and Capabilities:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- ◆ **Participant Safeguards:** *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- ◆ **Participant Rights and Responsibilities:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- ◆ **Participant Outcomes and Satisfaction:** *Participants are satisfied with their services and achieve desired outcomes.*
- ◆ **System Performance:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

System performance measures, outcome measures and satisfaction measures include the following:

1. The percentage of CFC applicants for whom state or local contract staff has completed a level-of-care assessment to determine institutional level of care eligibility prior to enrollment. Numerator = number of enrolled applicants who have a completed level of care assessment. Denominator = total number of files reviewed of enrolled applicants for CFC services.
2. The percentage of CFC participants whose CFC eligibility was determined using the appropriate processes and instruments and according to the approved description. Numerator: CFC participants whose CFC eligibility was determined using the appropriate processes and instruments according to the approved description. Denominator: All files reviewed of CFC participants found eligible for services.
3. The percentage of providers of CFC services plan that meet required licensure and/or certification under Oregon Administrative Rule. Numerator: Providers that prior to delivering CFC services initially met and continue to meet licensure and/or certification requirements. Denominator: All files reviewed in which providers delivering CFC services require licensure and/or certification.

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5. The percentage of providers who are trained per Oregon Administrative Rules and the approved CFC. -
Numerator: CFC service providers that are trained per Oregon Administrative Rules and the approved CFC. -
Denominator: All CFC services provider for files reviewed.
6. The percentage of participants whose service plans address assessed needs and personal goals per
approved procedures. Numerator: Participants whose service plans address assessed needs and personal
goals per approved procedures. Denominator: All CFC participant service plans reviewed.
7. All participants have a written and authorized service plan in accordance with Oregon Administrative Rules.
Numerator: All participants with a written and authorized service plan in accordance with OAR.
Denominator: All participants' service plans reviewed.
8. The percentage of service plans that are updated or revised annually. Numerator: Plans that are renewed
within 12 months from the previous service plan. Denominator: All service plans reviewed.
9. The percentage of service plans that are revised when warranted by a change in needs. Numerator: Service
plans that are revised when participant needs change. Denominator: All service plans reviewed.
10. The percentage of services delivered in accordance with what is specified in the service plan including the
type, scope, duration and frequency. Numerator: Service plans for which services delivered are in
accordance with the type, scope, duration and frequency specified in the plan. Denominator: All service
plans reviewed.
11. Individuals are offered the choice of CFC services and offered choice of qualified providers. Numerator:
Participants who are offered choice of CFC services and qualified providers. Denominator: All CFC
participants reviewed.
12. Individuals are offered the choice between CFC services and institutional care. Numerator: Number of
participants offered the choice between CFC services and institutional care. Denominator: All CFC services
recipients reviewed.
13. The percentage of participants who are victims of substantiated abuse, neglect or exploitation. Numerator:
Participants who are victims of substantiated abuse, neglect or exploitation. Denominator: All CFC
participant files reviewed.

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14. Identified individual risk and safety considerations are addressed taking into account the individual's informed and expressed choices. Numerator: Identified risks and safety considerations addressed taking into account the individual's informed and expressed choices. Denominator: All CFC participant files reviewed.
15. The percentage of claims that are authorized and paid for in accordance with reimbursement specified in the approved CFC. Numerator: Reimbursements that are authorized and paid for in accordance with the methods specified in the approved CFC. Denominator: All reimbursements for files reviewed.
16. Percent of individuals who express that their services and supports are meeting their needs. Numerator: Number of service recipients who express their service needs are being met. Denominator: All service recipients who respond to the satisfaction survey.
18. Percent of individuals who express that they are able to direct their services. Numerator: Number of service recipients who express they are able to direct their services. Denominator: All service recipients who respond to the satisfaction survey.

Measurement of individual outcomes associated with the receipt of community-based attendant service and supports.

Every two years, DHS will survey statistically valid sample of individuals receiving CFC services to determine their satisfaction and outcomes related to the CFC services. The survey will include an assessment of the individual's opinion in progress towards goals identified by the individual in their person-centered service plan. The survey will also address the quality of care about the service provider. DHS will monitor length of stay in the service setting to determine the stability of the person-centered service plan.

DHS shall ensure that all individuals receiving CFC services and supports have access to all of the protections in the state's abuse, neglect and exploitation protection including mandated reporting, investigation and resolution of allegations of neglect, abuse, and exploitation. Oregon law defines mandatory reporters, types of abuse and consequence and remediation in appropriate cases. DHS shall follow these statutes and the corresponding administrative rules. In addition to abuse reports required by statute for older adults, people with developmental disabilities and people with mental illness, all staff shall report abuse for individuals under age 65. Protective service workers will investigate any allegation.

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Standards for service delivery models for:

Training

Each provider type has specific training requirements described in Oregon Administrative Rule, as listed in the provider qualifications. Provider training may be provided by DHS, professional associations and independent trainers. Trainings are targeted to individuals, to specific provider types and delivery systems to ensure that the special needs of any particular population are addressed effectively. Person-centered plan coordinators receive training that includes formal training curriculum on person centered planning and philosophy and other critical case management activities. Person-centered plan coordinators and state trained assessors receive initial and ongoing training. Training includes working with consumers, eligibility, how to lead a functional needs assessment with the consumer, person-centered planning, choice counseling to ensure free choice of providers and service settings, service options and delivery systems, protective services, addressing needs of special populations.

Denials and Reconsiderations

DHS has standardized forms and processes for informing individuals/ representatives of rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/representatives of the hearing outcomes.

DHS communicates additions or revisions to forms and processes to local, state or contracted case management entities through formal electronic transmittals.

Individual service recipients and applicants, and their representatives, are provided timely written notice of any planned change in services or benefits, including denial, closure or reduction. For denials, the time frame is 45 days from the date of application. For closure or reduction of benefits or services the time frame is 10 working days prior to the effective date of the proposed action. The notice includes the reason for DHS' decision, administrative rules that support the decision and the individual's/representative's right to due process through an administrative hearing process.

Appeals

The local, state or contracted case management entity notifies the individual about the Fair Hearing process during the initial assessment/service planning. As part of the notification of Fair Hearings procedure, the person-centered plan coordinator informs the individual that continuation of services must be requested by the individual under the timeframes specified in OAR.

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Results of the hearing are provided to the individual in the form of a Hearing Order written by the Administrative Law Judge. The Hearing Order is mailed to the individual.

Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.

Local, state or contracted case management entities fully inform individuals of all available choices and service options. Documentation requirements and automated systems support quality assurance efforts. The QA processes defined above includes ensuring that individuals were fully informed of their options and their ability to direct their own service plan. This is monitored by eligible individual satisfaction surveys. QA teams meet with individuals receiving services in each local office audit to ensure eligible individual choice was offered and honored.

Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.

The Department has established Development and Implementation Council, the majority of which is comprised of individuals with disabilities, elderly individuals and their representatives. The Department consults and collaborates with the Council on a regular basis to inform and elicit feedback regarding the services and supports provided to individuals receiving CFC services.

The methods used to continuously monitor the health and welfare of Community First Choice individuals

local, state or contracted case management entities regularly monitor service plans to ensure the health and welfare of individuals receiving CFC services. Through the use of risk management agreements, a monitoring plan is developed with the individual to review services and supports. Individuals receiving CFC services are informed of their right to request a review of their PCSP to ensure that their health and safety needs are being met through their self-directed service plan.

Abuse investigation services, as described above, are also a means of monitoring the health and welfare of CFC individuals.

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The Quality Assurance Team reviews are a source of administrative review of the health and welfare of individuals. The QA Team reviews, as described above, result in corrective action plans both for individuals and on a system-wide basis.

The methods for assuring that individuals are given a choice between institutional and community-based services

DHS assures that individuals who are eligible for services under CFC will be informed of feasible alternatives for community-based services and given a choice as to which type of service to receive. When an individual is determined to require the level of care provided in an institution, the individual or his or her representative will be:

- 1) Informed of any feasible alternatives available under CFC or the applicable HCBS Waiver, and
- 2) Given the choice of either institutional or home and community-based services. The choice of institutional or home and community-based services is documented on each eligible individual's record. Person-centered plan coordinators are responsible for collecting the appropriate Freedom of Choice documentation.

State Name: Oregon

Transmittal Number: OR-23-0009

Attachment 3.1-L

OMB Control Number: 0938-1148

Alternate Benefit Plan Populations	ABP1				
<p>Identify and define the population that will participate in the Alternative Benefit Plan. Alternative Benefit Plan Population Name: New Adult group: Program code AMO</p> <p>Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.</p> <p>Eligibility Groups Included in the Alternative Benefit Plan Population:</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%;">Eligibility Group:</td><td style="width: 50%;">Enrollment is mandatory or voluntary</td></tr><tr><td>Adult group</td><td>Voluntary</td></tr></table> <p>Enrollment is available for all individuals in these eligibility group(s). <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Geographic Area</p> <p>The Alternative Benefit Plan population will include individuals from the entire state/territory. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any other information the state/territory wishes to provide about the population (optional)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Eligibility Group:	Enrollment is mandatory or voluntary	Adult group	Voluntary
Eligibility Group:	Enrollment is mandatory or voluntary				
Adult group	Voluntary				
Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act					
ABP2a					
<p>The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.</p> <p>The ABP is aligned with the current secretary approved OHP benefit package approved via the 1115 demonstration waiver. This benefit contains all 10 of the essential health benefits as well as additional categories not covered by the base benefit plan. The ABP meets or exceeds the base benchmark benefits.</p>					

TN No. 23-0009

Approval Date: 5/11/23

Effective Date: 1/1/23

Supersedes TN No.22-0024

State Name: Oregon

Transmittal Number: OR-23-0009
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OMB Control Number: 0938-1148

Voluntary Benefit Package Selection Assurances- Eligibility group under
Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

he state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes No

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The ABP is aligned with the current secretary approved OHP benefit package approved via the 1115 demonstration waiver. This benefit contains all 10 of the essential health benefits as well as additional categories not covered by the base benefit plan. The ABP meets or exceeds the base benchmark benefits.

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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP 3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
 The state/territory is creating a single new benefit package for the population defined in Section 1.
Name of benefit package: Oregon Health Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
 Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Health Benefit Program (FEHBP).
 State employee coverage that is offered and generally available to state employees (State Employee Coverage):

A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

- Secretary-Approved Coverage.
 The state/territory offers benefits based on the approved state plan.
 The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

- The state/territory offers the benefits provided in the approved state plan.
 Benefits include all those provided in the approved state plan plus additional benefits.
 Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
 The state/territory offers only a partial list of benefits provided in the approved state plan.
 The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations.

Selection of base benefit plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

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The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Yes No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name: PacificSource Preferred CoDeduct Value 3000 35 70

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

It is Oregon's intention to provide the expansion population with the full set of Medicaid benefits provided to the State's categorically eligible population. This approach will help minimize disruptions for individuals who move among different benefit packages within The Oregon Health Plan. Under our authority for Secretary-approved coverage as an ABP, CMS is approving a package of benefits that the state has determined includes at least all essential health benefits as defined using the required process, and other benefits that are both:1) covered in accordance with the traditional benefit package under the approved state plan and 2) included on the states prioritized list, as approved by the Secretary, to the extent that the state has authority under its section 1115 demonstration to apply the prioritized list to coverage.

Oregon is proposing to use the PacificSource Preferred CoDeduct Value 3000 35 70 small group plan as the base benchmark plan for the ABP. This plan was also chosen by Oregon as the State's essential health benefits benchmark plan in the commercial market. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

State Name: Oregon

Transmittal Number: OR-23-0009
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Alternative Benefit Plan Cost-Sharing	ABP4
<input checked="" type="checkbox"/> Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.	
Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.	
The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Other Information Related to Cost Sharing Requirements (optional):	
<div style="border: 1px solid black; height: 30px;"></div>	

Benefits Description	ABP5
The state/territory proposes a "Benchmark-Equivalent" benefit package.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Benefits Included in Alternative Benefit Plan	
Enter the specific name of the base benchmark plan selected:	
<div style="border: 1px solid black; padding: 2px;">PacificSource Preferred CoDeduct Value 3000 35 70</div>	
Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."	
<div style="border: 1px solid black; padding: 2px;">Secretary-Approved</div>	
**Essential Health Benefits align with OHP Plus. For full descriptions of ABP5 refer to CMS Approval package.	

<input checked="" type="checkbox"/> Essential Health Benefit 1: Ambulatory patient service	
<u>Benefit Provided:</u> Physician services	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Oregon utilizes a Patient Centered Primary Care type medical home model. The primary care provider is a gatekeeper for specialty care however, some services or procedures may require a prior authorization such as transplants; MRI; bariatric surgeries, etc	
<u>Benefit Provided:</u> Nurse Practitioner	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Nurse Practitioners under state law function autonomously and generally follow a model similar to a Patient Centered Primary Care home. The primary care provider is a gatekeeper for specialty care however, some services or procedures may require a prior authorization such as transplants; MRI; bariatric surgeries, etc	
<u>Benefit Provided:</u> Chiropractor	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	

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

Benefit Provided:

Family Planning

Source:

State Plan 1905(a)

Authorization :

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit

None

Scope Limit:

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

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

Benefit Provided:

Podiatrist services (OLP)

Source:

State Plan 1905(a)

Authorization :

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit

None

Scope Limit:

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

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

Benefit Provided:

Optometrist services (OLP)

Source:

State Plan 1905(a)

Authorization :

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit

None

<p><u>Scope Limit:</u> <input type="text" value="Services provided within the scope of practice as defined under state law."/></p> <p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p>	
<p><u>Benefit Provided:</u> Tobacco cessation</p> <p><u>Authorization :</u> None</p> <p><u>Amount Limit:</u> None</p> <p><u>Scope Limit:</u> <input type="text" value="Services provided within the scope of practice as defined under state law."/></p> <p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input type="text"/>	<p><u>Source:</u> State Plan 1905(a)</p> <p><u>Provider Qualifications:</u> Medicaid State Plan</p> <p><u>Duration Limit</u> None</p>
<p><u>Benefit Provided:</u> Outpatient hospital</p> <p><u>Authorization :</u> None</p> <p><u>Amount Limit:</u> None</p> <p><u>Scope Limit:</u> <input type="text" value="Services provided within the scope of practice as defined under state law."/></p> <p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input type="text"/>	<p><u>Source:</u> State Plan 1905(a)</p> <p><u>Provider Qualifications:</u> Medicaid State Plan</p> <p><u>Duration Limit</u> None</p>
<p><u>Benefit Provided:</u> Hospice</p> <p><u>Authorization :</u> None</p>	<p><u>Source:</u> State Plan 1905(a)</p> <p><u>Provider Qualifications:</u> Medicaid State Plan</p>

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<u>Amount Limit:</u> None	<u>Duration Limit</u> 90 day period with subsequent 60-day periods
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Certification of terminal illness required from physician, informed consent, etc. Concurrent care is provided to children, includes age 19 & 20).	

<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services	
<u>Benefit Provided:</u> Outpatient hospital services	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 	
<u>Benefit Provided:</u> Emergency-Physician services	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 	

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<u>Benefit Provided:</u>	<u>Source:</u>
Emergency-medical transportation-outpt hsp	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
None	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	

<input checked="" type="checkbox"/> Essential Health Benefit 3: Hospitalization	
<u>Benefit Provided:</u>	<u>Source:</u>
Inpatient hospital	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
Other	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
Some procedures or services may require a prior authorization such as transplants; MRI; bariatric surgeries, etc. The Physician is responsible to obtain the authorization for the procedure.	

<u>Benefit Provided:</u>	<u>Source:</u>
Physician-inpatient hospital	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
Other	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	

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

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

Essential Health Benefit 4: Maternity and newborn care

<u>Benefit Provided:</u>	<u>Source:</u>
Maternity care-Physician services	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
None	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None

Scope Limit:

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

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

<u>Benefit Provided:</u>	<u>Source:</u>
Maternity care-Nurse practitioner	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
None	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None

Scope Limit:

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

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

<u>Benefit Provided:</u>	<u>Source:</u>
Maternity care-Nurse Midwife	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
None	Medicaid State Plan

<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	

<input checked="" type="checkbox"/> Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment	
<u>Benefit Provided:</u>	<u>Source:</u>
Inpatient hospital-MH/SUD	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
None	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
These hospital services are acute care hospitals and are not an IMD.	
<u>Benefit Provided:</u>	<u>Source:</u>
Outpatient hospital-MH/SUD	State Plan 1905(a)
<u>Authorization :</u>	<u>Provider Qualifications:</u>
None	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
None	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
Most outpatient hospital services would not be rehabilitative or habilitative and would be acute situations taking them to an outpatient ED. Most rehabilitative or habilitative would be provided in residential facilities or office settings.	

<u>Benefit Provided:</u> Physician services -MH/SUD	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 	
<u>Benefit Provided:</u> Nurse practitioner -MH/SUD	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 	
<input checked="" type="checkbox"/> Essential Health Benefit 6: Prescription drugs	
<u>Benefit Provided:</u> Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark .	
Prescription Drug Limits (Check all that apply.):	<u>Authorization:</u> <u>Provider Qualifications:</u>
<input checked="" type="checkbox"/> Limit on days supply	<input checked="" type="checkbox"/> Yes State Licensed
<input type="checkbox"/> Limit on number of prescriptions	
<input type="checkbox"/> Limit on brand drugs	
<input type="checkbox"/> Other coverage limits	
<input checked="" type="checkbox"/> Preferred drug list	
Coverage that exceeds the minimum requirements or other: The State of Oregon's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.	

<input checked="" type="checkbox"/> Essential Health Benefit 7: Rehabilitative and habilitative services and devices	
<u>Benefit Provided:</u> Inpatient hospital- Rehabilitative	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Rehabilitative - these services are acute care hospitals and are not an IMD.	
<u>Benefit Provided:</u> Outpatient hospital- Rehabilitative	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 	
<u>Benefit Provided:</u> Physical,speech & occupational therapy- Reh/Hab	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Services and limits per plan of care, some services require authorization, limits can be exceeded when medically necessary	

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<u>Benefit Provided:</u> Home health- Reh/Hab	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Service authorization varies, this benefit includes DME, PT,OT, speech services provided in a home setting. Services and limits per plan of care, some services require authorization, limits can be exceeded when medically necessary.	
<u>Benefit Provided:</u> Prosthetic devices- Rehab/Hab	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some prosthetic devices require prior authorization. These include but are not limited to lumbar orthotics, spinal orthotics, orthopedic shoe, shoulder-elbow orthotics. Limits can be exceeded when medically necessary.	
<u>Benefit Provided:</u> Eyeglasses	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Prior Authorization	<u>Provider Qualifications:</u> Medicaid State Plan

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<u>Amount Limit:</u> Limits for non-pregnant adults age 21 and over	<u>Duration Limit</u> Limits for non-pregnant adults age 21 and over
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Limits to non-pregnant adults age 21 and over: Routine vision services for the sole purpose of eyeglasses, are not covered. Coverage does include emergency eye exams and treatment and Non-emergency visual services with specific medical diagnoses.	
<u>Benefit Provided:</u> Dentures	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> Prior Authorization	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> Limits for age 21 and over	<u>Duration Limit</u> Limits for age 21 and over
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Dentures are used to replace, correct, or support a full or partial set of teeth. For ages 21 and older full dentures are limited to 1 every 10 years and partial dentures are limited to 1 every 5 years, exceptions are made when dentally appropriate.	

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<u>Benefit Provided:</u> Nursing Facility Services-Skilled	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> Level of care needs	<u>Duration Limit</u> Level of care needs
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Screening and assesment to determine level of care needs.	

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services	
<u>Benefit Provided:</u> Laboratory & X-ray	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 	

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

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

<u>Benefit Provided:</u> Preventive services	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law	

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

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

<u>Benefit Provided:</u> Medicaid State Plan EPSDT Benefits	<u>Source:</u> State Plan 1905(a)
<u>Authorization :</u> None	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law	

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

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

Base Benchmark Benefit that was Substituted:

Primary care to treat illness/injury

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Specialist visits

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Outpatient Surgery

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Acupuncture</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Acupuncture services were bundled, along with Primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services and nurse practitioner services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Chiropractic</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Chiropractic services were bundled, along with primary care to treat illness/injury and specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of chiropractic (OLP) services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Naturopath</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Naturopathic services were bundled, along with Primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.</p>	

Base Benchmark Benefit that was Substituted:

Chemotherapy services

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Radiation therapy

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Sterilization

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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Base Benchmark Benefit that was Substituted:

Home health care

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Telemedical services

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Care for disease of the eye

Source:

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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<p><u>Base Benchmark Benefit that was Substituted:</u> Foot care</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Foot care services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of physician and podiatrist (OLP) services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Medical contraceptives</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Medical contraceptives services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'ambulatory patient services' EHB category. The bundled services are a duplication of family planning services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Emergency room-facility</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Emergency room - facility services were bundled, along with emergency room visits and mapped to the 'emergency services' EHB category. The bundled services are a duplication of Emergency Hospital -Outpatient services from the existing state Medicaid plan.</p>	

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<p><u>Base Benchmark Benefit that was Substituted:</u> Emergency room-Physician</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Emergency room-physician services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the 'emergency services' EHB category. The bundled services are a duplication of emergency-physician services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Emergency medical transportation</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Emergency medical transportation were bundled, along with emergency room visits and mapped to the 'emergency services' EHB category. The bundled services are a duplication of Emergency medical transportation-Outpatient hospital from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Inpatient medical and surgical care</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Inpatient medical and surgical care were bundled, along with inpatient hospital visits and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.</p>	

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Base Benchmark Benefit that was Substituted:

Source:

Bariatric surgery

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Source:

Anesthesia

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

Base Benchmark Benefit that was Substituted:

Source:

Breast reconstruction (non-cosmetic)

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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<p><u>Base Benchmark Benefit that was Substituted:</u> Blood transfusions</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Blood transfusions services were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital and physician-inpatient services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Hospice/respice care</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Hospice / respice care services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the "Ambulatory patient services" EHB category. The bundled services are a duplication of hospice services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Pre- & postnatal care</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Pre- & postnatal care services were bundled, along with Maternity services and mapped to the 'maternity and newborn care' EHB category. The bundled services are a duplication of maternity care-physician, maternity care-nurse practitioner, maternity care-nurse midwife services from the existing state Medicaid plan.</p>	

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<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Delivery & inpatient maternity services</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Delivery & inpatient maternity services were bundled, along with Maternity services and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Inpatient hospital-mental/behavioral health</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Inpatient hospital - mental/behavioral health services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Inpatient hospital-MH/SUD, physician-MH/SUD, nurse practitioner-MH/SUD, services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Outpatient hospital-mental/behavioral health</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Outpatient hospital - mental/behavioral health services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Outpatient hospital-MH/SUD, physician services-MH/SUD and nurse practitioner-MH/SUD services from the existing state Medicaid plan.</p>	

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<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Inpatient hospital-chemical dependency</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Inpatient hospital - chemical dependency services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Inpatient hospital-MH/SUD, physician services-MH/SUD and nurse practitioner-MH/SUD services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Outpatient hospital-chemical dependency</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Outpatient hospital - chemical dependency services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of Outpatient hospital-MH/SUD, physician services-MH/SUD and nurse practitioner-MH/SUD services from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Detoxification</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Detoxification services were bundled, and mapped to the 'Mental Health and substance use disorder services, including behavioral health treatment' EHB category. The bundled services are a duplication of inpatient hospital, outpatient hospital, physician services and nurse practitioner services and the mental health and substance use disorder section from the existing state Medicaid plan.</p>	

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<p><u>Base Benchmark Benefit that was Substituted:</u> Inpatient rehabilitation</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Inpatient rehabilitation services were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of inpatient hospital, rehabilitative section from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Physical, speech & occupational therapy</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Physical, speech & occupational therapy (outpatient) services were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled s services are a duplication of Physical, speech & occupational therapy from the existing state Medicaid plan..</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Durable medical equipment</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Durable medical equipment were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of home health-medical supplies from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Prosthetics</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Prosthetics were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of prosthetic devices and home health-Rehab/Hab from the existing state Medicaid plan.</p>	

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<p><u>Base Benchmark Benefit that was Substituted:</u> Orthotics</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Orthotics were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of prosthetic devices and home health-Rehab/Hab from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Hearing aids</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Hearing aids were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of physical, speech & occupational therapy, language disorders section from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Cochlear implants</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Cochlear Implants were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of prosthetic devices, physical, speech & occupational therapy, language disorders section from the existing state Medicaid plan.</p>	

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<p><u>Base Benchmark Benefit that was Substituted:</u> Lab test, x-ray services & pathology</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Lab tests, x-ray services, & pathology were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Imaging/diagnostics (e.g., MRI,CT,PET scan)</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Imaging / diagnostics (e.g., MRI, CT ,PET scan) were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u> Genetic teting</p>	<p><u>Source:</u> Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Genetic testing services were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.</p>	

<u>Base Benchmark Benefit that was Substituted:</u> Preventive services	<u>Source:</u> Base Benchmark
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:	
Preventive care services were bundled, and mapped to the 'Preventive and wellness services and chronic disease management' EHB category. The bundled services are a duplication of Preventive services from the existing state Medicaid plan.	
<u>Base Benchmark Benefit that was Substituted:</u> Smoking/Tobacco cessation program	<u>Source:</u> Base Benchmark
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:	
Smoking/Tobacco cessation program were bundled, and mapped to the 'Ambulatory patient services' EHB category. The bundled services are a duplication of tobacco cessation sections from the existing state Medicaid plan.	
<u>Base Benchmark Benefit that was Substituted:</u> Eyeglasses	<u>Source:</u> Base Benchmark
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:	
Eyeglasses were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of eyeglasses section from the existing state Medicaid plan.	

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<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Dentures</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Dentures were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of dentures section from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Skilled nursing</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Skilled Nursings were bundled, and mapped to the 'Rehabilitative and habilitative services and devices' EHB category. The bundled services are a duplication of Skilled Nursing Facility section from the existing state Medicaid plan.</p>	
<p><u>Base Benchmark Benefit that was Substituted:</u></p>	<p><u>Source:</u></p>
<p>Outpatient hospital</p>	<p>Base Benchmark</p>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p>	
<p>Outpatient hospital - facility services were bundled, and mapped to the 'Outpatient hospital' EHB category. The bundled services are a duplication of Hospital - Outpatient services from the existing state Medicaid plan.</p>	

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<u>Base Benchmark Benefit that was Substituted:</u>	<u>Source:</u>
Organ & tissue transplants	Base Benchmark
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:	
Organ & tissue transplants were bundled, along with Inpatient medical and surgical care and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.	
<u>Base Benchmark Benefit that was Substituted:</u>	<u>Source:</u>
Newborn child coverage	Base Benchmark
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:	
Newborn services are billed separately through the newborn's Medicaid ID	

<input checked="" type="checkbox"/> 14. Other 1937 Covered Benefits that are not Essential Health Benefits	
<u>Other 1937 Benefit Provided:</u>	<u>Source:</u>
Dental	Section 1937 Coverage Option Benchmark Benefit Package
<u>Authorization :</u>	<u>Provider Qualifications:</u>
Prior Authorization	Medicaid State Plan
<u>Amount Limit:</u>	<u>Duration Limit</u>
Limits for age 21 and older	None
<u>Scope Limit:</u>	
Services provided within the scope of practice as defined under state law.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
Dental services for adults include the prevention and amelioration of dental disease states, limits on dentures, crown and periodontal coverage. Pregnant women receive additional services similar to children.	

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<p><u>Other 1937 Benefit Provided:</u> Clinic services</p> <p><u>Authorization :</u> None</p> <p><u>Amount Limit:</u> None</p> <p><u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.</p> <p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> </p>	<p><u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package</p> <p><u>Provider Qualifications:</u> Medicaid State Plan</p> <p><u>Duration Limit</u> None</p>
<p><u>Other 1937 Benefit Provided:</u> Targeted Case Management</p> <p><u>Authorization :</u> Other</p> <p><u>Amount Limit:</u> None</p> <p><u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.</p> <p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <div style="border: 1px solid black; padding: 5px;"> Targeted groups are HIV/AIDS, EI/ECSE, Babies First, Tribal members, Healthy Homes (Asthma), Children Who Are the Responsibility of Child Welfare, Self sufficiency and Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18. </div> </p>	<p><u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package</p> <p><u>Provider Qualifications:</u> Medicaid State Plan</p> <p><u>Duration Limit</u> None</p>
<p><u>Other 1937 Benefit Provided:</u> Non emergency medical transportation</p> <p><u>Authorization :</u> Prior Authorization</p> <p><u>Amount Limit:</u> None</p> <p><u>Scope Limit:</u> Services provided within the scope of practice as defined under state law or Administrative rule.</p>	<p><u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package</p> <p><u>Provider Qualifications:</u> Medicaid State Plan</p> <p><u>Duration Limit</u> None</p>

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Other:

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

Other 1937 Benefit Provided:

Private duty nursing services

Authorization :

Prior Authorization

Amount Limit:

None

Scope Limit:

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

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Provider Qualifications:

Medicaid State Plan

Duration Limit

None

Other:

Must meet the level of service criteria and nursing services must be medically appropriate and based on a physician's order.

Other 1937 Benefit Provided:

Intermediate care facility services -ICF/IDD
Package

Authorization :

Other

Amount Limit:

None

Scope Limit:

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

Source:

Section 1937 Coverage Option Benchmark Benefit

Provider Qualifications:

Medicaid State Plan

Duration Limit

None

Other:

Level of care assessment.

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<u>Other 1937 Benefit Provided:</u> Extended services for pregnant women	<u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
<u>Other:</u> An initial needs assessment to assess the basic needs of the expectant mother and develop a client service plan (CSP) to optimize pregnancy outcomes. The program is referred to as the Maternity Case Management program.	

<u>Other 1937 Benefit Provided:</u> Personal Care services	<u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
<u>Other:</u> Authorized based upon the plan of treatment or service plan. Personal Care Services include Activities of Daily Living (ADLs) as outlined in the Medicaid state plan.	

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<u>Other 1937 Benefit Provided:</u> Nursing Facility Services-Long Term	<u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> Level of care need	<u>Duration Limit</u> Level of care need
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other: Screening and assessment to determine level of care needs.	

<u>Other 1937 Benefit Provided:</u> PACE	<u>Source:</u> Section 1937 Coverage Option Benchmark Benefit Package
<u>Authorization :</u> Other	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other: Participants eligible for PACE are 55 or older, meet the state's criteria for long-term care eligibility with a service priority level of 1-13, and are Medicaid eligible.	

<u>Other 1937 Benefit Provided:</u> Patient Cost in Qualifying Clinical Trials Benefit Package	<u>Source:</u> Section 1937 Coverage Option Benchmark Routine
<u>Authorization :</u> Yes	<u>Provider Qualifications:</u> Medicaid State Plan
<u>Amount Limit:</u> None	<u>Duration Limit</u> None
<u>Scope Limit:</u> Services provided within the scope of practice as defined under state law.	
Other: See applicable Attachment 3.1-B & Attachment 4.19-B for coverage and reimbursement of routine costs in qualifying clinical trials in Oregon's Medicaid state plan.	

State Name: Oregon

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Other 1937 Benefit Provided:

Preventive Svcs: Community Violence Prevention

Source:

Section 1937 Coverage Option Benchmark Benefit

Authorization :

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Same as the Medicaid State plan

Duration Limit

Same as the Medicaid State plan

Scope Limit:

Same as the Medicaid State, Attachment 3.1-A

Other:

As described in Attachment 3.1-A of the Medicaid State Plan. Community violence prevention services are a new category of service within the preventive services Medicaid state plan benefit category pursuant to 42 CFR 440.130(c). The purpose of this service is to help mitigate and prevent community violence and its effects on Medicaid members.

See Attachment 3.1-A for details regarding this benefit, including service description and provider qualifications.

TN No. 23-0009

Approval Date: 5/11/23

Effective Date: 1/1/23

Supersedes TN No.22-0024

State Name: Oregon

Transmittal Number OR-23-0009
Attachment 3.1-L

OMB Control Number: 0938-1148

Benefit Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes No

The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

Through an Alternative Benefit Plan.

Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

--

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

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Approval Date: 5/11/23

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State Name: Oregon

Transmittal Number OR-23-0009
Attachment 3.1-L

OMB Control Number: 0938-1148

Benefit Assurances	ABP7
Prescription Drug Coverage Assurances (Cont)	
<input checked="" type="checkbox"/> The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.	
<input checked="" type="checkbox"/> The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.	
<input checked="" type="checkbox"/> The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.	
Other Benefit Assurances	
<input checked="" type="checkbox"/> The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.	
<input checked="" type="checkbox"/> The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.	

State Name: Oregon

Transmittal Number OR-23-0009
Attachment 3.1-L

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Benefits Assurances	ABP7
<input checked="" type="checkbox"/> The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.	
<input checked="" type="checkbox"/> The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.	
<input checked="" type="checkbox"/> The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.	
<input checked="" type="checkbox"/> The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.	
<input checked="" type="checkbox"/> The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.	
<input checked="" type="checkbox"/> The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).	

TN No. 23-0009
Supersedes TN No.22-0024

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Service Delivery Systems	ABP8
<p>Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.</p>	
<p>Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Managed care. <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Managed Care Organizations (MCO). <input type="checkbox"/> Prepaid Inpatient Health Plans (PIHP). <input type="checkbox"/> Prepaid Ambulatory Health Plans (PAHP). <input checked="" type="checkbox"/> Primary Care Case Management (PCCM). <input checked="" type="checkbox"/> Fee-for-service. <input type="checkbox"/> Other service delivery system. 	
<p>Managed Care Options</p>	
<p>Managed Care Assurance</p> <p><input checked="" type="checkbox"/> The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.</p>	
<p>Managed Care Implementation</p> <p>Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.</p>	
<div style="border: 1px solid black; padding: 10px;"> <p>Individuals on the OHP Standard Reservation List were mailed a letter in September that explains how they may apply for Medicaid expansion benefits for January 1, 2014. The Authority is coordinating mailings to potential new eligibles prevent duplicate contacts. OHP Standard beneficiaries with a renewal date after December 31, 2013 will be converted to the Medicaid expansion program effective January 1, 2014. An eligibility-related notice will be mailed explaining the new program; providing an overview of changes to the beneficiaries' benefit plan coverage and explaining reporting requirements. The notice will also be sent with information about managed care enrollment and benefit coverage. Notices for current clients in OHP Standard moving to OHP Plus inform them that they will qualify for OHP Plus services on 1/1/14. We explain that OHP Plus covers more services than OHP Standard and we list those services. We explain that their health plan and providers won't change and contact information is provided if they have questions. Outreach included a letter to all affected clients in November 2013. We held a client focus group that reviewed the letter, created a fact sheet that is currently posted on the web. For providers we plan to mail a letter explaining the change, and revised OARs as needed. Information is/was shared with stakeholders at partner meetings and presentations and the Authority worked with the CCOs to coordinate member communications.</p> </div>	

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes No

The managed care program is operating under (select one):

Section 1915(a) voluntary managed care program.

Section 1915(b) managed care waiver.

Section 1932(a) mandatory managed care state plan amendment.

Section 1115 demonstration.

Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

As authorized under an 1115 Demonstration Waiver Oregon's delivery system transitioned from using separate Managed Care Entities (MCE) known as Fully Capitated Health Plans (FCHP), Dental Care Organizations (DCO) and Mental Health Organizations (MHO) to Coordinated Care Organizations (CCO) beginning in August 2012. A CCO is an MCE responsible for physical, dental, and behavioral health services, all of which were previously provided through the aforementioned separate MCEs; CCOs are located throughout the state.

As a result of this transition, the state's direct contracts with DCOs covered only fee-for-service OHP beneficiaries. Initially, CCOs were required by Oregon law to provide dental services for their members by contracting with any DCO in its service area; these contracts were required to be in place by July 2014. This is no longer required so CCOs can choose whether to contract with DCOs, with dental providers directly, or both.

Effective 1/1/23, fee-for-service OHP beneficiaries served under the state's direct contracts with DCOs will be transitioned into the CCOs for dental services. As a result, OHA will only hold direct contracts with CCO entities.

OHA previously transitioned Non-Emergent Medical Transportation (NEMT) from the 1915(b) waiver authority to the 1115 Demonstration for both coordinated care and fee-for-service OHP beneficiaries.

The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCO

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. **Yes**

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

Name	Description
Prescription drugs	Services reimbursed under FFS for those enrolled in CCOs include: Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents dispensed through a licensed pharmacy.
Hospice	Services reimbursed under FFS include: Hospice services for Members who reside in a Skilled Nursing Facility.
Lont term care	Services reimbursed under FFS include: Nursing Facility services, HCBS, PACE and ICF/IID services.
Abortions	Services reimbursed under FFS for those enrolled in CCOs include: Therapeutic abortions (abortions comport with the Hyde amendment).

MCO service delivery is provided on less than a statewide basis. **No**

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: **No**

Other MCO-Based Service Delivery System Characteristics(Cont)**General MCO Participation Requirements**

Indicate if participation in the managed care is mandatory or voluntary:

- Mandatory participation.
 Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Auto-assigned to a CCO through an auto-enrollment process. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled). Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment. Refer to Project Number 21-W-00013/10 and 11-W-00160/10) STC of Oregon's 1115 demonstration waiver.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. **Yes**

The PCCM program is operating under (select one):

- Section 1915(b) managed care waiver.
 Section 1932(a) mandatory managed care state plan amendment.
 Section 1115 demonstration.
 Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: **July 16, 2021**

Describe program below:

This is an Indian Managed care Entity PCCM program. Refer to detail in TN21-0008

- The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

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PCCM Procurement or Selection Method

Indicate the method used to select PCCMs:

- Competitive procurement method (RFP, RFA).
 Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

Indian Manage Care Entity for voluntary enrollment of American Indians Alaskan Natives. refer to details in TN 21-0008

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. **No**

PCCM service delivery is provided on less than a statewide basis. **No**

PCCM Payments

Specify how payment for services is handled:

- Per member/per month case management fee paid to PCCM provider.
 Other:

Additional Information: PCCM (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- Traditional state-managed fee-for-service
 Services managed under an administrative services organization (ASO) arrangement

Fee-For-Service Options(Cont)

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The FFS program operates under an 1115 Demonstration waiver as well as 1902(a) state plan coverage. Once determined eligible, an individual will be in FFS for a period of time. The majority of these individuals will be enrolled in a CCO within 2 weeks of determination. Populations that are not enrollable into a CCO would receive services through this FFS option such as non-citizen emergency medical known in Oregon as Citizen Waived Emergency Medical (CWEM). OHA previously transitioned Non-Emergent Medical Transportation (NEMT) from the 1915(b) waiver authority to the 1115 Demonstration for fee-for-service. Services not included in CCOs and reimbursed under FFS for those enrolled in CCOs include items such as: Standard therapeutic lass 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents, Hospice services for Members who reside in a Skilled Nursing Facility, Long term care services (PACE, HCBS) and Therapeutic abortions (abortions comport with the Hyde amendment).

State Name: Oregon

Transmittal Number OR-23-0009

Attachment 3.1-L

OMB Control Number: 0938-1148

Employer Sponsored Insurance and Payment of Premiums	ABP9
<p>The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:</p> <div data-bbox="272 890 1451 1142" style="border: 1px solid black; padding: 5px;"><p>For a Medicaid beneficiary who receives coverage in a health plan in the individual market through the state’s approved Medicaid state plan that provides premium assistance under section 1905(a) and regulations codified at 42 CFR §435.1015, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits around the individual market health plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.”</p></div> <p>The state/territory otherwise provides for payment of premiums. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Other Information Regarding Employer Sponsored Insurance or Payment of premiums:</p> <div data-bbox="228 1283 1451 1323" style="border: 1px solid black; height: 19px;"></div>	

State Name: Oregon
OMB Control Number: 0938-1148

Transmittal Number OR-23-0009
Attachment 3.1-L

General Assurances	ABP10
Economy and Efficiency of Plans	
<input checked="" type="checkbox"/> The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.	
Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Compliance with the Law	
<input checked="" type="checkbox"/> The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.	
<input checked="" type="checkbox"/> The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).	
<input checked="" type="checkbox"/> The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.	

Payment Methodology	ABP11
Alternative Benefit Plans - Payment Methodologies	
<input checked="" type="checkbox"/> The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.	
Attachment Submitted:	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

TN No. 23-0009

Approval Date: 5/11/23

Effective Date: 1/1/23

Supersedes TN No.22-0024

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

Transmittal #87-17
Attachment 3.2-A

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State OREGON
COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

- /X/ A. Buy-in agreement with the Secretary of HHS. This agreement covers:
1. / / Individuals receiving SSI under title XVI or State supplementation who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

 Yes No
 2. / / Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

 Yes No
 3. /X/ All individuals eligible under the State's approved title XIX plan.
- / / B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:
- /X/ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:
- All Medicaid eligible persons who are also Medicare eligible, with a maximum-combined Medicare/Medicaid payment not to exceed Oregon's Medicaid fee.

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. . . . if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-\$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement Attachment.

TN # 87-17
SupersedesTN#

Approval Date 7/6/87

Effective Date 4/1/87

HCFA ID: 1048P/0016P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

GENERAL PROGRAM ADMINISTRATION

Pharmacy Lock-in program:

Clients with suspect utilization patterns that indicate patient safety issues or risk of drug misuse may be locked-in to a single pharmacy for a period of 18 months. The criteria used to determine who should be lock-in are, but not limited to; use of 3 or more pharmacies in 6 months; use multiple prescribers to obtain the same or comparable drugs, or exhibit patterns of drug misuse. The Oregon DUR/P&T Committee develops standards to be used in retrospective and prospective drug utilization review in a manner that insures that such criteria and standards are based on the compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, data and experience obtained from drug utilization review program operations.

Once the client has been identified to be in the program a notice is sent that includes the pharmacy the client is assigned to, the effective date and the right to change the pharmacy assigned within 45 days and administrative appeal rights.

Clients are allowed to use the Division's mail-order pharmacy and/or the Pharmacy they are assigned. Clients can change the assigned pharmacy for circumstances such as a move out of the area.

Exemptions from the lock-in; if they are enrolled in Managed care, covered by Medicare part D, a child in state custody or inpatient or resident in a hospital, NF or other medical facility. Emergency situations have provisions for an exception from lock-in.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

The standards specified in paragraphs (a) and (b) on page 42 of the Plan are:

Surveys are conducted in accordance with the Interagency Agreement between the Oregon Health Authority (OHA) and the Department of Human Services (DHS).

The Department of Human Services conducts Medicare and Medicaid qualifying surveys on a schedule that meets criteria established by the Centers for Medicare and Medicaid Services (CMS). Additional standards for which Long-term Care Facilities are accountable are found in Oregon Revised Statutes (ORS) section 441.

The Department of Human Services, Seniors and People with Disabilities division is responsible for nursing facilities.

UTILIZATION REVIEW METHODS FOR INTERMEDIATE CARE FACILITIES

1. 42 CFR 456
Effective: July 1, 1985

The State of Oregon assures that it will meet the conditions of 42 CFR Part 456, Subpart F, for utilization control in Intermediate Care Facilities by review by medical professionals of the Senior Services Division.

2. 42 CFR 456
Effective: July 1, 1982

The utilization review functions in Intermediate Care Facilities for the Mentally Retarded will continue to be provided by the State of Oregon, Department of Human Resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

N/A (Oregon is not a TEFRA lien state.)

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

N/A

3. The State defines the terms below as follows:

- o **ESTATE:** For medical assistance provided prior to July 18, 1995, estate is defined as all real and personal property and other assets included within the individual's, or the individual's surviving spouse's, probatable estate. For medical assistance provided after July 18, 1995, estate also includes all real and personal property and other assets in which the deceased individual had any legal title or interest at the time of death including assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other similar arrangement. Under other similar arrangement, the State will pursue recovery against an annuity that was the property of the deceased Medicaid beneficiary.
- o **INDIVIDUAL'S HOME** means any dwelling unit in which an individual has an ownership interest and is used as the individual's principal place of residence; such dwelling unit may consist of a house, boat, trailer, mobile home or other habitation. It is the dwelling that the individual considers his or her fixed or permanent residence and to which, whenever absent, the person intends to return. The individual's home includes the real property on which the dwelling is located, all tangible personal property located therein, and any related outbuildings necessary to its operation. Only one dwelling unit may be considered an individual's home. Outbuildings necessary to the operation of the home include

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

outdoor toilets, garage, shed, spring or well house, and barns or other buildings that house animals used for the individual's consumption. An individual's home, in most instances, is located within the state of Oregon. However, an individual's home may be located outside the state of Oregon.

- o **EQUITY INTEREST IN THE HOME** means the value of an individual's home less the unpaid principal balance of any loans or other liens or encumbrance affecting the individual's home.
- o **RESIDING IN THE HOME FOR AT LEAST ONE OR TWO YEARS ON A CONTINUOUS BASIS** means uninterrupted residence by an individual in the individual's home, provided, however, that such residence may be interrupted by absences from the home if, while absent, the individual has the intent to return home.
- o **LAWFULLY RESIDING** means that an individual has a legal right to reside in an individual's home.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

4. The State defines undue hardship as follows:

The Department may waive enforcement of any estate recovery claim if it finds that enforcing the claim would result in an undue hardship to the beneficiaries, heirs, or family claiming entitlement to receive the assets of the deceased client. In determining whether an undue hardship exists, the Department may consider whether enforcement of the claim would cause the waiver applicant to become eligible for public or medical assistance and become homeless. (ORS 416.340)

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

At the discretion of the Department, waiver of an estate recovery claim may include, but is not limited to, forgiveness of all or part of the claim, or taking a promissory note and mortgage or trust deed in lieu of immediate enforcement of the claim.

No waiver may be granted if the Department finds that the undue hardship was created by resort to estate planning methods by which the waiver applicant or deceased client divested, transferred, or otherwise encumbered assets, in whole or in part, to avoid estate recovery.

No waiver will be granted if the Department finds that the undue hardship will not be remedied by the grant of the waiver.

The Department will provide written notice of the hardship waiver rules to the personal representative or other person handling the deceased client's estate, and other persons as described in the Department's rules.

Persons claiming entitlement to receive assets may apply for a hardship waiver by submitting a written request to the Department. The information to be included on the request is specified in the Department's rules.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

Each Estate Administrator has the authority to determine if an estate will be pursued for collection based on the likelihood of recovering the value of the claim as it compares to the cost of collection.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

Upon the death of a recipient of assistance subject to recovery, and provided the recipient has no surviving spouse, minor child, or a child who is blind or disabled according to SSI criteria, and provided there is no real property or titled personal property which would require the filing of an estate proceeding, (small estate or probate), the Department may claim any funds up to \$25,000 which belonged to the recipient and which are on deposit with a bank (ORS 708.430), savings and loan (ORS 722.262), or credit union (ORS 723.463).

When the Estate Administration team receives a report on deceased persons meeting the conditions above, the team sends the banking letter, an affidavit, and indemnity agreement to the identified financial institution claiming the account of the decedent. Individuals who contact us and notify us of creditors who have a priority before the State are advised to send the billings to the Estate Administrator and the bill is satisfied to the extent that the assets are available, e.g., funeral expenses.

A small estate may be filed when an individual dies leaving an estate with a fair market value of \$140,000.00 or less; not more than \$50,000.00 attributable to personal property and not more than \$90,000.00 attributable to real property. An affidavit may not be filed until 30 days after the death of the decedent. A probate proceeding can be filed at any time for an estate of any dollar value or when the value of the estate exceeds the small estate limitations.

Revision: HCFA-PM-95-3 (MB)
May 1995

Transmittal #02-01
Attachment 4.17-A
Page 2-b

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

If, after sufficient passage of time, neither the heirs nor devisees have filed an estate proceeding, then the Department handling the estate, under the authority of Oregon Revised Statutes, has the authority to act as the personal representative or nominate a personal representative. The practice of Estate Administration is to nominate a personal representative.

In both situations, the Estate Administration Unit files the written notice with the personal representative or claiming successor and provides a copy to the probate court of our claim as a priority creditor. The heirs or the personal representative has the right to deny the claim and a summary determination will occur in Probate Court.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: **OREGON**

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount of Basis for Determination
	Deduct.	Coins.	Copay.	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Premiums Imposed on Low Income Pregnant Women and Infants

- A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:
- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-25
Supersedes
TN No. _____

Approval Date 1/23/92

Effective Date 11/1/91
HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:
- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-25
Supersedes
TN No.

Approval Date 1/23/92

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HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

C. State or local funds under other programs are used to pay for premiums:

/ / Yes / / No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

TN No. 91-25
Supersedes
TN No. _____

Approval Date 1/23/92

Effective Date 11/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SUBJECT: Methods and Standards Used for Payment of Reasonable Costs of Inpatient Psychiatric Hospital Services

A. Psychiatric Hospitals

Payments to certified portions of participating psychiatric hospitals for the provision of active inpatient treatment services to Title XIX eligible patients will be made by the Mental Health and Developmental Disability Services Division ("the Division") on the basis of billings submitted to the Office of Medical Assistance Programs. The method of payment is based on annual review and analysis of allowable costs reported by all participating psychiatric hospitals and features the use of interim per diem rates and retrospective (year-end and final) cost settlements capped by a maximum allowable rate for each contract period.

Establishing a Base Year Rate and Subsequent Maximum Allowable Rates

1. In order to establish a base year rate, the Division used cost statements from all Oregon Hospitals licensed as psychiatric hospitals.
2. If a psychiatric hospital's cost report was for a period either longer or shorter than 12 months, the Title XIX allowable costs reduced or increased as appropriate by multiplying the total allowable costs by the ratio that 12 months bore to the number of months in the hospital's report period. This procedure resulted in a prorated 12-month cost projection for use in establishing the statewide average per diem rate for the base period.
3. If a psychiatric hospital had a fiscal period other than the base period, the hospital's Title XIX allowable costs were adjusted by applying the relevant inflation factors from the Medicare market basket index issued by the Health Care Financing Administration so that the Title XIX costs corresponded to the base period. The inflation factors were applied to the interval between the midpoint of the hospital's fiscal period and the mid-point of the base period. The number of Title XIX patients days in the hospital's fiscal period was used as the number of days in the base period.

4. The total Title XIX allowable costs (including costs of patients receiving benefits through a managed care entity) from all hospitals included in the base period divided by the total number of Title XIX patient days (including such patients who receive benefits through a managed care entity) from all hospitals included in the base period yielded the state-wide average per diem costs (maximum allowable rate) for the base period. The statewide average per diem cost for the base period has been used as the fixed base for determining the maximum allowable reimbursement rate for any subsequent fiscal period.
5. The maximum allowable reimbursement rate for each new fiscal period is calculated by inflating the maximum allowable reimbursement rate for the previous period by the annual Health Care Financing Administration target percentages for Prospective Payment System excluded hospitals (as published in the Federal register). This percentage increase is applied from the mid-point of the previous period to the mid-point of the 12-month period for which the rate is being established.
6. When a currently enrolled psychiatric hospital has a fiscal period other than that used by the state, July 1 through June 30, the applicable maximum allowable reimbursement rate for each month will be the same as the maximum allowable rate in effect that month for hospitals operating under the State fiscal period.

Interim Rate Setting

At least annually, the Division will establish an interim Medicaid per diem rate for each participating psychiatric hospital, separate cost entity or distinct program within a hospital:

- a. If a hospital requests an interim per diem rate, the Division will review the request. The Division will consider the hospital's prior year cost report, inflation factors, changes in patient populations and programs, appropriate capital allowances, whether the hospital will qualify as a disproportionate share hospital, and other relevant factors. Based upon the findings of the review, the Division will either approve the interim rate as proposed or establish a different interim rate;
- b. If a hospital does not request an interim per diem rate, the Division will establish an interim rate using the relevant factors from subsection "a" of this part of the State plan.

Retrospective Settlement Rate (Year-End) and Quarterly Disproportionate Share Payments

1. A retrospective year-end settlement rate will be determined for each participating hospital, separate cost entity or distinct program within a hospital on the basis of Division review of actual allowable costs reported in the hospital's cost statement.
 - a. Each settlement rate will be the rate determined by dividing the applicable Title XIX allowable costs by the applicable number of Title XIX patient days, including therapeutic leave days, or the maximum allowable reimbursement rate, whichever is less. Therapeutic leave days are a planned and medically authorized period of absence from the hospital not exceeding 72 hours in 7 consecutive days.
 - b. A "separate cost entity" is determined by Medicare.
 - c. A "distinct program" is determined by the Division. The criteria used to make the determination are:
 - A. The inpatient psychiatric hospital must be participating in Medicaid;
 - B. The hospital must have a specialized inpatient active psychiatric treatment program of 50 or more beds based upon patient age or medical condition;
 - C. The program must have unique admission standards;
 - D. The nursing staff must be specifically assigned to the program and will have experience or training in working with the specialized population; and
 - E. The program must have a record-keeping system that accounts for revenues and expenditures for the program separate from those for the general psychiatric hospital.

2. Payment to disproportionate share hospitals. A participating psychiatric hospital may be reimbursed for allowable costs in excess of the maximum rate if it meets the criteria in section 1923(b) and (d) of the Social Security Act:
- a. The hospital serves disproportionate numbers of low-income persons: i.e., has a low income utilization rate which exceeds 25 percent using the following formula:
 - A. The total Medicaid revenues paid to the hospital for patient services under the State plan, plus the amount of the cash subsidies for patient services received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period. The percentage derived in A. shall be added to the following percentage:
 - B. The total amount of the hospital's charges for inpatient psychiatric services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for inpatient services received directly from state and local governments described in "A" above in the period attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient psychiatric services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical Assistance under an approved Medicaid State Plan).

The sum of percentages derived in "A" and "B" shall exceed 25 percent in order to qualify as a disproportionate share hospital; or

- b. The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State. The term "Medicaid inpatient utilization rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity) under an approved Oregon State plan in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere; and
- c. The hospital has, at a minimum, a Medicaid inpatient utilization rate of one percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX) inpatient days (regardless of whether those days are attributable to patients who receive medical assistance on a fee-for-service basis or through a managed care entity) to total inpatient days. Information on total inpatient days is taken from the most recent audited Medicare and Medicaid cost reports. Information on total paid Medicaid days is taken from the Division's reports of paid claims for the same fiscal period as the Medicare Cost Report; and
- d. The hospital has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State plan.

NOTE: This requirement does not apply to a hospital -

- i. the inpatients of which are predominantly individuals under 18 years of age; or
- ii. which does not offer non-emergency obstetric services to the general population as of December 21, 1987.

- 3. If the hospital has more than one settlement rate, the average Medicaid settlement rate for the hospital may not exceed the maximum allowable rate unless the hospital meets the disproportionate share criteria. The average Medicaid settlement rate is developed by multiplying each proposed settlement rate by Medicaid patient days for that, rate adding the products together, and dividing the resulting sum by total Medicaid patient days for the hospital.

4. For inpatient psychiatric hospitals that meet the disproportionate share criteria, as defined in Section 2 above, there shall be an additional quarterly disproportionate share reimbursement in excess of the maximum allowable rate after the end of each quarter. The disproportionate share adjusted rate will be calculated as follows:
- a. The disproportionate share reimbursement for all psychiatric hospitals except those meeting the additional criterion in Section 4b will be 135 percent of the maximum allowable rate.
 - b. If a psychiatric hospital has a low-income rate of **at least** 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:
 - o public funds, excluding Medicare and Medicaid
 - o bad debts
 - o free care,The hospital qualifies to receive disproportionate share payment at a rate based on 100 percent of the costs of uncompensated care during the facility's previous fiscal year.
 - c. The Division will base quarterly disproportionate share reimbursements on the estimated costs for each facility during the current fiscal year and will review and adjust the reimbursements, after conclusion of the fiscal period, to correspond with actual costs encountered during the period. Total reimbursement from disproportionate share and other sources will not exceed actual costs.
 - d. Effective April 1, 1995, and in accordance with the Omnibus Budget Reconciliation Act of 1993, disproportionate share payments to public hospitals will not exceed 100 percent of the unpaid costs, defined as follows:
 - (1) The inpatient costs for services to Medicaid patients, less the amounts paid by the State under non-disproportionate share hospital payment provisions of the State plan, plus;
 - (2) The inpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who does not have health insurance coverage that will reimburse any of the costs of the services delivered nor access to other resources to cover such costs. The costs attributable to uninsured patients are determined through disclosures in the Medicare and Medicaid cost reports and state records on indigent care.

Public hospitals that qualify under the "Transition Year Rule" as a high disproportionate share hospital may receive disproportionate share payments not to exceed 200 percent of the unpaid costs discussed previously. A high disproportionate share public hospital must have a Medicaid utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State. The Governor of the State of Oregon, through signatory delegation to the Director of the Department of Human Resources, will also certify that the "applicable minimum amount" will be used for health care services. The applicable minimum amount is the difference between the amount of the disproportionate share hospital payment and the amount of the unpaid cost.

The State has a contingency plan to ensure that disproportionate share hospital payments will not exceed the "State Disproportionate Share Psychiatric Hospital Allotment." In order to assure compliance with the requirements of section 1923(f) of the Social Security Act, the State will review the "Allotment" to make sure that each quarter's payments do not exceed the allotment. If the anticipated payments exceed the allotment, payments will be reduced until these anticipated payments are equal to the amount of the allotment. Reductions will apply equally to all psychiatric hospitals, based on a prior quarterly disproportionate share payment for each hospital compared to total disproportionate share payments in the same quarter. If previous payments in the Federal Fiscal Year exceed that year's allotment, the current quarterly payment will not be paid to the provider until the overpayment has been recovered. A Hospital's payment adjustment will also be reduced in this manner if the payment adjustment exceeds the cost limits expressed by Section 1923(g) of the Social Security Act.

The overpayment will be withheld from interim payments if the recovery cannot otherwise be made within 60 days of the date of the findings.

5. The year-end settlement will be determined by multiplying the average settlement rate by the total number of Title XIX patient days, including therapeutic leave days or, for disproportionate share hospitals, multiplying the disproportionate share adjusted rate by the total number of Title XIX patient days, including therapeutic leave days.

6. In the aggregate, payments for hospitals will not exceed the upper limits described in 42 CFR 447.253. Disproportionate share payment adjustments to the Medicaid settlement rate will be subtracted from aggregate hospital payments before findings with regard to 42 CFR 447.253 are made.
7. Payments to providers will not be increased, solely as a result of change of ownership in excess of the increase which would result from applying 1861(v)(1)(0) of the Social Security Act as applied to owners of record on or after July 18, 1984.

Retrospective Settlement Rate (Final)

1. The final settlement process will be as follows:
 - a. Upon receipt of the final Medicare Cost Report from the Medicare Intermediary, the hospital provider will prepare a final Medicaid cost report.
 - b. Using the final Medicaid cost report developed in subsection "a" of this part of the State plan, the Division will calculate the final settlement rate and settlement for each participating hospital, separate cost entity or distinct program within a hospital, following the steps outlined in parts 1 through 7 of the previous section.

Appeals Procedure

Letters will be sent notifying the provider of the interim per diem rate, the year-end settlement rate, the final settlement rate, or the quarterly disproportionate share finding. A provider shall notify the Division in writing within 15 days of receipt of a letter if the provider wishes to appeal the rate or finding. Letters of appeal must be postmarked within the 15-day limit.

TN # 01-09 DATE APPROVED July 10, 2001
SUPERSEDES TN 95-01

EFFECTIVE DATE April 1, 2001

STATE OF OREGON

1. (Reserved for future use)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (A) of this State plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

TN No. 11-16

Approval Date: 6/18/12

Effective Date: 10/1/2011

Supersedes TN No. 96-15

CMS ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State: OREGON

METHODS AND STANDARDS FOR PAYMENT OF INPATIENT MEDICAL HOSPITAL SERVICES

Inpatient hospital rates are not applicable for Hospital-Acquired Conditions (HAC) that are identified as non-payable by Medicare. This policy applies to all Medicaid reimbursement provisions contained in section 4.19-A, including supplemental payments and Medicaid disproportionate share hospital payments.

1. TYPE A AND TYPE B RURAL OREGON HOSPITALS

The definition of Type A and Type B hospitals is contained in ORS 442.470. The responsibility for designating Type A and Type B hospitals was assigned to the Office of Rural Health, Department of Higher Education. Type A and Type B hospitals receive retrospective cost-based reimbursement for all covered inpatient services effective with admissions occurring on or after July 1, 1991.

Costs are derived from the most recent audited Medicare Cost Report and are adjusted to reflect the Medicaid mix of services.

Type A and B hospitals are eligible for disproportionate share reimbursements, but do not receive cost outlier, capital, or medical education payments.

2. HOSPITALS PROVIDING SPECIALIZED INPATIENT SERVICES

Some hospitals provide specific highly specialized inpatient services by arrangement with DMAP. Reimbursement is made according to the terms of a contract between DMAP and the hospital. The rate is negotiated on a provider-by-provider basis and is a rate sufficient to secure necessary services. When the service is provided by an out-of-state hospital, the rate is generally the rate paid by the Medicaid program of the state in which the provider is located. In all instances, the negotiated rate is a discounted rate.

3. FREE-STANDING INPATIENT PSYCHIATRIC FACILITIES (IMDS)

Free-standing inpatient psychiatric facilities (Institutions for Mental Diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the terms of an agreement between the Division of Addiction and Mental Health (AMH) and the hospital. The reimbursement for a unit of service is sourced from the departmental fee schedule and paid as a daily rate.

TN No. 10-17

Approval Date: 2/15/11

Effective Date: 1/1/2011

Supersedes TN No. 06-04

4. SPINAL CORD INJURED PROGRAM

Reimbursement under the Spinal Cord Injured program is made on a prospective payment basis for inpatient rehabilitative services provided by CARF or JCAHO-Rehab. certified facilities for treatment of severe disabling spinal cord injuries for persons who have exhausted their hospital benefit days. Services must be authorized by the Spinal Cord Injured Committee in order for payment to be made.

5. INPATIENT RATE CALCULATIONS FOR OTHER HOSPITALS: DRG METHODOLOGY

A. OREGON ACUTE CARE HOSPITALS

(1) DIAGNOSIS RELATED GROUPS

Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) MEDICARE GROUPEUR

The Medicare Grouper is the software used to assign individual claims to a DRG category. Medicare revises the Grouper program each year in October.

OMAP uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals which may be affected by grouper logic changes in reaching a cooperative decision regarding changes.

(3) DRG RELATIVE WEIGHTS

Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category.

For most DRGs, OMAP establishes a relative weight based on Federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric, Oregon Title XIX fee-for-service claims history is used. OMAP employs the following methodology to determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG.

Using the formula $N = ((Z * S)/R)^2$, where $Z = 1.15$ (a 75% confidence level), S is the Standard Deviation, and $R = 10\%$ of the mean, OMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5).

For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, OMAP sets a relative weight using:

OMAP non-Title XIX claims data, or

Data from other sources expected to reflect a population similar to the OMAP Title XIX caseload.

When a t-test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the OMAP Title XIX population in that DRG, the weight derived from OMAP Title XIX claims history is used instead of the externally-derived weight for that DRG.

“Pen and Ink” Change

Those relative weights, based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by OMAP. When relative weights are recalculated, the overall average CMI will be kept constant. Re-weighting of the DRGs or the addition or modification of the group logic will not result in a reduction of overall payments or total relative weights.

(4) CASE MIX INDEX

The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(5) UNIT VALUE

Per Oregon Administrative Rule 410-125-0141 effective as of October 1, 2009 as it relates to the unit value for hospitals larger than 50 beds, reimbursed using the Diagnosis Related Grouper (DRG), the Unit Value rebased methodology effective for services beginning on or after October 1, 2009 has been established as a percentage of the current year published Medicare Unit Value (Labor and Non-Labor), update each October thereafter.

The Unit Value plus the Capital amount multiplied by the claim assigned DRG relative weight is the hospital's Operational Payment.

Effective for services provided on or after March 1, 2004, the Unit Value for DRG hospitals will be determined according to subsection (5). The Department of Human Services, as informed by the Legislative Assembly, Emergency Board, or the Department of Administrative Services, will determine the aggregate reduction or increase required to adjust the Unit Value. The adjustment percentage of Medicare's Unit Value will be determined by dividing the aggregate reduction or increase by the current hospital budget. The current Unit Value for each hospital will then be multiplied by the adjustment percentage to determine the net amount of decrease or increase in the hospital's current Unit Value. This amount will be applied to each hospital's current Unit Value to determine the new Unit Value for the individual hospital. The Division, in accordance with 42 CFR 447.253 and 447.205, will make public notice of changes and amend the state plan whenever a Unit Value adjustment is made under the provision of this subsection.

(6) DRG PAYMENT

The DRG payment to each hospital is calculated by multiplying the Relative Weight for the DRG by the Hospital-Specific Unit Value. This is referred to as the Operational Payment.

(7) COST OUTLIER PAYMENT'S

Cost outlier payments are an additional payment made to DRG hospitals. An outlier payment will be made at the time a claim is processed for exceptional costs or exceptionally long lengths of stay provided to Title XIX clients.

Effective for services beginning on or after March 1, 2004, the calculation to determine the cost outlier payment for all hospitals is as follows:

- Non-covered services (such as ambulance charges) are deducted from billed charges.
- The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid case load.
- If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than \$25,000, an additional cost outlier payment is made.

- Costs which exceed the threshold (\$25,000 or 270% of the DRG payment, whichever is greater) are reimbursed at a percentage. The percentage of net costs (costs above the threshold) to be paid is established by OMAP and may be adjusted monthly as needed to maintain total cost outlier expenditures for the 1993-95 biennium at \$9.0 million in Total Funds, excluding cost outlier payments made to Oregon Health Sciences University Medical Center.

- Third party reimbursements are deducted from the OMAP calculation of payable amount.

Formula for Cost Outlier Calculation:

$$\begin{array}{rcl} & & \text{Billed charges less non-covered charges} \\ \text{X} & & \text{Hospital-specific cost-to-charge ratio} \\ = & & \text{Net Costs} \\ - & & \text{270\% of the DRG or \$25,000 (whichever is greater)} \\ = & & \text{Outlier Costs} \\ \text{X} & & \text{Cost Outlier Percentage} \\ = & & \text{Cost outlier Payment} \end{array}$$

The cost outlier percentage necessary to fully expend the cost outlier pool is estimated to be 30% for the biennium. OMAP will reimburse cost outlier claims at 50% of costs above the threshold and will monitor payments to determine the relationship between projected and actual outlier payments. An adjustment to the 50% reimbursement rate will be made as needed to fully expend the cost outlier pool. The amount of the cost outlier pool will not be exceeded. Cost outlier payments made to Oregon Health Sciences University Medical Center will not be deducted from this pooled amount.

When hospital cost reports are audited, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred.

The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and OMAP 42, adjusted to reflect the Medicaid mix of services.

(8) CAPITAL

The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. Oregon's Medical Assistance Programs uses the Medicare definition and calculation of capital costs. Effective October 1, 2009, the Division of Medical Assistance Programs will use the current federal fiscal year Medicare reimbursement capital cost per discharge methodology and rate for Oregon Medicaid discharges.

Capital cost per discharge is calculated as follows:

- a. The capital cost reimbursement rate is established as 100% of the published Medicare capital rate for the current federal fiscal year .
- b. The capital cost is added to the Unit Value and paid per discharge. Reimbursement of capital at time of claim payment enhances hospital financial health.

(9) GRADUATE DIRECT MEDICAL EDUCATION (GDME)

The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Medical Assistance Programs uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report). Direct Medical Education is included in the capitation rates paid to managed care plans under the Oregon Health Plan 1115 Demonstration Project.

Direct Medical Education cost per discharge is calculated as follows:

The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is divided by the number of Title XIX non-Medicare. This is the Title XIX Direct Medical Education Cost per discharge.

The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded CMS DRI market basket adjustment.

Direct Medical Education Payment Per Discharge

The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%.

The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors. All inflationary increases will be submitted through amendments to the State plan.

Payment is made within thirty days of the end of the quarter.

(10) GRADUATE INDIRECT MEDICAL EDUCATION (GIME)

The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients. Indirect Medical Education is included in the capitation rates paid to managed care plans under the Oregon Health Plan 1115 Demonstration Project.

Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs.

Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the State's fiscal year is the Medical Assistance Programs indirect medical education factor. This factor is used for the entire Oregon fiscal year.

The calculation for the Indirect Medical Education Factor is as follows:

$$\begin{array}{rcl} \text{Total relative weights from claims paid during the quarter} & & \\ \times & \text{Indirect Medical Education Factor} & \\ = & \text{Indirect Medical Education Payment} & \end{array}$$

This determines the current quarters Indirect Medical Education payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

(11) Graduate Medical Education Reimbursement for Public Teaching Hospitals

The Graduate Medical Education (GME) payment is reimbursement to an institution for the costs of an approved medical training program. The State makes GME payments to non-Type A and B inpatient acute hospitals based on the number of fee-for-service hospital inpatient discharges as provided in (11) Direct Medical Education and (12) Indirect Medical Education. Funding for GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans. Since a significant portion of Medicaid payments for acute inpatient hospital discharges are made through managed care plans, an additional payment for GME is necessary to ensure the integrity and quality of medical training programs.

The additional GME payment is a reimbursement to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. This reimbursement is in addition to that provided under (11) Direct Medical Education or (12) Indirect Medical Education.

For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (base year). Total Direct Medical Education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME costs.

Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount - other than outlier payments, outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

The additional GME payment is calculated as follows:

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Total Title XIX GME is the sum of Title XIX IME and DME costs. Payments for Title XIX fee-for-service IME and DME are then subtracted from the Total Title XIX GME leaving the net unreimbursed Title XIX GME costs for the base year. The net unreimbursed Title XIX GME costs for the base year is then multiplied by CMS PPS Hospital Index. The additional GME payment is rebased yearly.

The additional GME reimbursement is made quarterly.

Total payments including the additional GME payments will not exceed that determined by using Medicare reimbursement principles. The Medicare upper limit will be determined from the most recent Medicare Cost Report and will be performed in accordance with 42 CFR 447.272. The upper limit review will be performed before the additional GME payment is made.

(12) DISPROPORTIONATE SHARE

The disproportionate share hospital (DSH) payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs.

To receive DSH payments under Criteria 1 and Criteria 2 described below, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital who performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital which had discontinued or did not offer non-emergency obstetric services as of December 22, 1987. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another state are also accounted for.

A hospital's eligibility for DSH payments is determined at the beginning of each State fiscal year. Hospitals which are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1. Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state.

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a. Criteria 1: One or more standard deviations above the mean.

The ratio of total paid Medicaid inpatient (Title XIX, non Medicare) days for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) to total inpatient days is one or more standard deviations above the mean for all Oregon hospitals.

Information on total inpatient days is taken from the most recent Medicare Cost Report. Total paid Medicaid inpatient days is based on DMAP records for the same cost reporting period.

Information on total paid Medicaid days is taken from Division of Medical Assistance Programs (DMAP) reports of paid claims for the same fiscal period as the Medicare Cost Report.

b. Criteria 2: A low Income Utilization Rate exceeding 25 percent.

The low income utilization rate is the sum of percentages (1) and (2) below:

(1) The Medicaid Percentage: The total of Medicaid inpatient and outpatient revenues paid to the hospital for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus any cash subsidies received directly from State and local governments in the most recent Medicare cost reporting period. This amount is divided by the total amount of inpatient and outpatient revenues and cash subsidies of the hospital for patient services in the most recent Medicare cost reporting period. The result is expressed as a percentage.

(2) The Charity Care Percentage: The total hospital charges for inpatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period, is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage.

Charity care is care provided to individuals who have no source of payment, including third party and personal resources.

Charity care shall not include deductions from revenues or the amount by which inpatient charges are reduced due to contractual allowances and discounts to other health insurance or third party payers, such as HMO'S, Medicare, Medicaid, etc.

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The information used to calculate the Low Income Utilization rate is taken from the following sources:

- The most recent Medicare Cost Reports.
- DMAP records of payments made during the same reporting period.
- Hospital provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period.
- Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period.
- Any other information which DMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

DMAP determines within 30 days of receipt of all required information if a hospital is eligible under the Low Income Utilization rate criteria.

Information on total inpatient days is taken from the most recent Medicare Cost Report.

Information on total paid Medicaid days is taken from DMAP reports of paid claims for the same fiscal period as the Medicare Cost Report.

c. Disproportionate Share Payment Calculations

All hospitals that have been deemed DSH hospitals will always qualify for DSH payments under Criteria 1 or Criteria 2. Hospital ranking is done on an annual basis for all hospitals. Once the eligible hospitals are determined DMAP calculates the standard deviations for the hospitals to determine if they will be eligible under Criteria 1 or Criteria 2.

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Criteria 1: One or more standard deviations above the mean.

The quarterly DSH payments to hospitals eligible under Criteria I is the sum of DRG weights for paid Title XIX non-Medicare claims for the previous quarter multiplied by a percentage of the hospital-specific Unit Value in effect for the current federal fiscal year. This determines the hospital's DSH payment for the current quarter. The Unit Value used for eligible Type A and Type B hospitals is the current Unit Value set at the 50th percentile. The calculation is as follows:

(1) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5 % to determine the DSH payment.

(2) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 10% to determine the DSH payment.

(3) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 25 % to determine the DSH payment.

Criteria 2: A low Income Utilization Rate exceeding 25 percent.

For hospitals eligible under Criteria 2 (Low Income Utilization Rate), the quarterly DSH payment is the sum of DRG weights for claims paid by DMAP in the quarter, multiplied by the hospital's disproportionate share adjustment percentage established under Section 1886(d)(5)(F)(iv) of the Social Security Act multiplied by the hospital's current federal fiscal year unit value. The Unit Value used for eligible Type A and Type B hospitals is the current Unit Value set at the 50th percentile.

Type A and Type B hospitals are assigned a DRG based upon the claim diagnosis code as all other hospitals are. The payment Type A and Type B hospital claim payment is not based upon the DRG but on the methods described in this state plan Attachment 4.19-A, page 6.

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Criteria 2: A low Income Utilization Rate exceeding 25 percent(Cont)

In-State public academic medical centers that provide a major medical teaching program, defined as a hospital with more than 200 residents or interns shall receive an additional 25% to the disproportionate share percentage described in criteria 1 and criteria 2 under the disproportionate share payment calculations.

Out-of-state hospitals

For out-of-state hospitals, the quarterly DSH payment is 5% of the out-of-state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals which have entered into agreements with DMAP are reimbursed according to the terms of the agreement or contract. The rate is negotiated on a provider-by-provider basis at a rate sufficient to secure necessary services. In general, the rate paid by State of Oregon is the rate paid by the Medicaid program of the state in which the provider is located. In all instances, the negotiated rate is a discounted rate.

d. Public Academic Medical Center Disproportionate Share Adjustments

Public academic medical centers that meet the following eligibility standards are deemed eligible for additional DSH payments up to 175% through June 30, 2005 and then revert to 100% thereafter of their uncompensated care costs for serving Medicaid clients, and indigent and uninsured patients:

- (1) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and
- (2) The hospital must be located within the State of Oregon (border hospitals are excluded); and
- (3) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

Uncompensated care costs for hospitals qualifying for this DSH payment will be determined using the following sources:

- The most recent Medicare Cost Reports.

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- DMAP's record of payments made during the same reporting period.
- Hospital provided financial statements prepared and certified for accuracy by a licensed public accounting firm.
- Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period.
- Any other information which DMAP, working in conjunction with representatives of qualifying Oregon hospitals, determines necessary to establish cost.

Separate calculations will be used to determine the uncompensated care costs for Medicaid clients and the uncompensated care costs for indigent and uninsured patients for each qualifying hospital.

1. Uncompensated Care Costs for Medicaid Clients

For the qualifying hospitals Medicaid charges for the state plan year be converted to Medicaid costs using the ratio of total costs to total charges. The resulting Medicaid costs are next reduced by Medicaid payments for the state plan year to arrive at Medicaid uncompensated care costs.

2. Uncompensated Care Costs for Indigent and Uninsured Patients

The uncompensated care costs for each year will be determined using the same methodology employed to determine the uncompensated care costs for Medicaid clients, but specifically related to indigent and uninsured patients.

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The final calculation to determine the additional DSH payment is summing the uncompensated care costs of the two components and reducing that amount by the graduate medical education reimbursement for public teaching hospitals (11) determined for the same payment year.

The additional DSH payment will be determined annually and is not subject to retrospective settlements/adjustments, except for adjustments for actual uncompensated care costs. Payment adjustments will be made quarterly.

e. Additional Disproportionate Payments

For all hospitals with a Medicaid utilization rate above 1% of all payer utilization, the DSH payment is the ratio of the hospital's low income shortfall to the low income shortfall for all eligible hospitals multiplied by the total Federal disproportionate share allotment remaining after disproportionate share payments have been made under c. and d. The low income shortfall is defined as Medicaid costs for inpatient and outpatient hospital services plus uncompensated care for the uninsured costs for inpatient and outpatient hospital services less total Medicaid and self-pay payments for inpatient and outpatient hospital services.

f. Disproportionate Share Payment Schedule

Hospitals qualifying for DSH payments under section (12)c and (12)e will receive quarterly payments based on claims paid during the preceding quarter. Payments are made within 30 days of the end of the quarter. Hospitals which were eligible during one fiscal year but are not eligible for disproportionate share status during the next fiscal year will receive DSH payments based on claims paid in the quarter in which they were eligible. Hospitals qualifying for DSH payments under section (12)d will receive quarterly payments of 1/4 of the amount determined under this section.

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Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, DSH payments to hospitals will not exceed 100 percent of the "basic limit", which is:

- (1) The inpatient and outpatient costs for services to Medicaid patients, less the amounts paid by the State under the non-DSH payment provisions of the State Plan, plus:
- (2) The inpatient and outpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who has no other resources to cover the costs of services delivered. The costs attributable to uninsured patients are determined through disclosures in the Medicare (HCFA-2552) cost report and state records on indigent care.

The state has a contingency plan to ensure that DSH payments will not exceed the "State Disproportionate Share Hospital Allotment." A reduction in payments in proportion to payments received will be effected to meet the requirements of section 1923(f) of the Social Security Act. DSH payments are made quarterly. Before payments are made for the last quarter of the Federal fiscal year, payments for the first three quarters and the anticipated payment for the last quarter are cumulatively compared to the "State Disproportionate Share Hospital Allotment." If the allotment will be exceeded, the DSH payments for the last quarter will be adjusted proportionately for each hospital qualifying for payments under section (12)d, first. If the Allotment will still be exceeded after this adjustment, DSH payments to out-of-state hospitals will be adjusted in proportion to DSH payments received during the previous three quarters. If this second adjustment still results in the Allotment being exceeded, hospitals qualifying for payments under section (12)c (Criteria 1 and 2) will be adjusted by applying each hospital's proportional share of payments during the previous three quarters to total DSH payments to all hospitals for that period. Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to DSH payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

(13) ONE-TIME DISPROPORTIONATE SHARE ALLOTMENT

This one time disproportionate share hospital (DSH) payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs and uncompensated care resulting from the 18-day hospital stay limitation. Twenty-one Oregon DRG hospitals qualify for this payment by serving a measurable percentage of low income patients with special needs whose hospital stay exceeded the 18-day hospital stay limitation. These 21 hospitals were ranked separately from the traditional DSH ranking process by calculating the individual percentage of Medicaid days to the total patient days. Each individual hospital receives their individual computed percentage applied to the uncompensated expenditures attributable to the 18-day hospital stay limitation total DSH payment of \$1,646,642.64 for this one time adjustment.

The time period for expenditures for these hospitals is 9/15/06 through 3/31/07

(14) PROPORTIONATE SHARE (Pro-Share) PAYMENTS FOR PUBLIC ACADEMIC TEACHING HOSPITALS

Proportionate Share will be made to public academic teaching hospitals in the State of Oregon with 200 or more interns or residents. Proportionate Share payments are subject to the federal Medicare upper payment limit for Inpatient hospital payments. The Medicare upper payment limit analysis will be performed prior to making the payments.

Eligible academic hospitals will be classified as either a (i) State owned or operated hospital, or (ii) non-State government owned or operated hospital. The Proportionate Share payment will be specific to each classification and determined as follows:

The federal upper payment limit is determined in accordance with the specific requirements for each hospital classification for all eligible hospitals during the State Fiscal Year 2001. The Proportionate Share payment is calculated by the determination of Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments. The State of Oregon Medicaid Management Information System (MMIS) is the source of the charge and payment data.

Proportionate Share payments will be made quarterly during each federal fiscal year. Payments made during federal fiscal year will not exceed the Medicare upper limit calculated from January 1, 2001 through September 30, 2001 and quarterly for each federal fiscal year thereafter.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SUPPLEMENTAL PAYMENTS

- a. Private Hospital Supplemental Payments
- b. From the private upper payment limit gap calculated in paragraph 8 of this section, payments shall be made to all private DRG hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of payment. This payment will be equal to one quarter of the gap amount divided by the total private DRG hospital Medicaid fee-for-service discharges from the quarter preceding the month of payment. The supplemental payments for Private Hospitals will not exceed the UPL for inpatient hospital services.
- c. Non-State Government Owned Hospital Supplemental Payments
- d. From the non-state government owned hospital upper payment limit gap calculated in paragraph 8 of this section, payments shall be made to all non-state government owned DRG hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of payment. This payment will be equal to one quarter of the gap amount divided by the total non-state government owned DRG hospital Medicaid fee-for-service discharges from the quarter preceding the month of payment. The supplemental payments for Non-State Government Owned Hospitals will not exceed the UPL for inpatient hospital services.

B. NON-CONTIGUOUS AREA OUT-OF-STATE HOSPITALS

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with ONLAP for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement. The Unit Value for non-contiguous out-of-state hospitals will be set at the Final Unit Value for the 50th percentile of Oregon hospitals (see DRG Rate Methodology for the methodology used to calculate the Final Unit Value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a Disproportionate Share reimbursement if eligible.

C. CONTIGUOUS AREA OUT-OF-STATE HOSPITALS

Contiguous Area Hospitals are out-of-state hospitals located less than 75 miles outside the border of Oregon. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement. The Unit Value for contiguous out-of-state hospitals will be set at the Final Unit Value for the 50th percentile of Oregon hospitals (see DRG Rate Methodology, for the methodology used to calculate the Unit Value at the 50th percentile.) Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a Disproportionate Share reimbursement if eligible.

D. DEATH OCCURRING ON DAY OF ADMISSION

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available from the fiscal year in which the admission occurred at the time the claim is processed.

E. TRANSFERS AND REIMBURSEMENT

When a patient is transferred between hospitals the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the Per Diem Inter-Hospital Transfer Payment rate.

5.E. TRANSFERS AND REIMBURSEMENT (Continued)

The Per Diem Inter-Hospital Transfer Payment rate = the DRG payment divided by the geometric mean length of stay for the DRG.

The final discharging hospital receives the full DRG payment.

Transfers from acute care to a distinct part rehabilitation unit within the same hospital shall be considered a discharge and readmission, with both admissions eligible for a separate DRG payment.

7. THIRD PARTY RESOURCES AND REIMBURSEMENT

- A. The Office of Medical Assistance Programs establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the OMAP maximum allowable payment.

OMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the OMAP reimbursement. OMAP will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

- B. When Medicare is Primary

OMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations sections above.

Payment is the OMAP allowable payment, less the Medicare payment, up to the amount of the deductible due. For clients who are Qualified Medicare beneficiaries OMAP does not make any reimbursement for a service which is not covered by Medicare. For clients who are Qualified Medicare/Medicaid beneficiaries OMAP payment is the allowable payment, less the Medicare payment, up to the amount of the deductible due for services covered by either Medicare or Medicaid.

- C. When Medicare is Secondary

Payment is the OMAP allowable payment, less the Medicare Part B payment.

- D. Clients with PCO or HMO Coverage

OMAP payment is limited to those services which are not the responsibility of the PCO or HMO. Payment is made at OMAP rates.

- E. Other Insurance

OMAP pays the maximum allowable payment, less any third party payments.

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The DMAP will not make any additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the DMAP reimbursement, or 100 percent of billed charges.

UPPER LIMITS ON PAYMENT OF HOSPITAL CLAIMS

A. CALCULATION OF UPPER PAYMENT LIMIT FOR DRG HOSPITALS

The following describes the steps followed in calculating the inpatient upper payment limit for Oregon for DRG hospitals. The data in this calculation comes from the most recently filed Medicare cost reports for each hospital and the corresponding Medicaid MMIS data.

1. The following Medicare payments subject to case mix were summed:

Worksheet E Part A lines 4.04, 17, 19, 20 and 26 less line 21.01

Worksheet E-3 Part I lines 5, 7, 9 and 17 less line 11.01

Worksheet E-3 Part I Subprovider I lines 5, 7, 9 and 17 less line 11.01

Worksheet E-3 Part I Subprovider II lines 5, 7, 9 and 17 less line 11.01

Worksheet E-3 Part II lines 20, 23 and 30 less line 25.01

2. The total from 1 was divided by the Medicare cases to determine a per case rate. Medicare cases for this were from. Medicare cases for this were from Worksheet S-3 Part I Col. 13 lines 12, 14 and 14.01.

3. The Medicare per case rate from 2 was divided by the hospital's applicable Medicare CMI to determine a per case rate with case mix removed.

4. Medicaid payments outlined in 4.19-A paragraph 5 sections 1-11 and 13-14 and cases subject to case mix were extracted from the OR MMIS Medicaid data.

5. The Medicare neutralized payments per case from 3 were multiplied by the hospital's Medicaid CMI to determine the hospital's estimated Medicaid payment per case based on the Medicaid case mix.

6. The estimated CMI-adjusted Medicaid payment per case was then multiplied by the hospital's Medicaid cases to determine the upper payment limit.

7. The Medicaid payments in 4. were then subtracted from that upper payment limit in 6. to establish the upper payment limit gap. Gaps across the state owned, non-state government owned, and private classes of hospitals were summed separately across classes and added to the amount calculated in B. to establish the aggregate upper payment limit gap for each class.

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B. CALCULATION OF UPPER PAYMENT LIMIT FOR NON-DRG HOSPITALS

The following describes the steps followed in calculating the inpatient upper payment limit for Oregon for non-DRG hospitals. The data in this calculation comes from the most recently filed Medicare cost reports for each hospital and the corresponding Medicaid MMIS data.

1. The following Medicare costs were summed:
Worksheet D-1 Part II line 49
Worksheet D-1 Part II Subprovider I line 49
Worksheet D-1 Part II Subprovider II line 49
Worksheet E-3 Part IV column 1 line 24
Worksheet D-6 Part III column 1 line 61
2. The following Medicare charges were summed:
Worksheet D-4 column 2 lines 25, 26, 27, 28, 29, 30 and 103
Worksheet D-4 Subprovider I column 2 line 103
Worksheet S-3 Part I column 4 line 14 divided by Worksheet S-3 Part I column 6 line 14 multiplied by Worksheet G-2 column 1 line 2
Worksheet D-4 Subprovider II column 2 line 103
Worksheet S-3 Part I column 4 line 14.01 divided by Worksheet S-3 Part I column 6 line 14.01 multiplied by Worksheet G-2 column 1 line 2.01
Worksheet D-6 Part III column 3 line 61
3. The total Medicare costs in 1. were then divided by the total Medicare charges in 2. to establish the CCR
4. Medicaid charges and payments were extracted from Medicaid data.
5. Medicaid charges were multiplied by the CCR in 3. to establish estimated Medicaid costs
6. Medicaid payments from 4. were then subtracted from the total in 5. to find the inpatient upper payment limit gap for the non-DRG hospitals. Gaps across the state owned, non-state government owned, and private classes of hospitals were summed separately across classes and added to the gaps calculated in A. to establish the aggregate upper payment limit gap for each class.

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C. PAYMENTS WILL NOT EXCEED FINALLY APPROVED PLAN

Total reimbursements to a State operated facility made during DMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

Total aggregate inpatient reimbursements to all hospitals made during DMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

DISALLOWED PAYMENTS

Payment will not be made to hospitals for non-emergency admissions if the appropriate prior authorization has not been obtained. Payment will not be made to hospitals for admissions determined not to be medically necessary. DMAP will not reimburse for non-covered services. DMAP may disallow payment for physicians' services provided during patient hospitalizations for which prior approval was required but not obtained.

APPEALS

Providers may request an appeal or exception to any State decision affecting payment rates. Providers may submit additional evidence and receive prompt administrative review as referenced in Oregon Administrative Rule.

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SPECIALTY HOSPITALS: Long-term care hospitals (LTACH)

The hospital rates and payment methods described in this attachment are for the State of Oregon Medicaid program. OHA will assign each specialty hospital to a reimbursement category based on the nature of the hospitals license, patient case mix, and current billing practices. LTACH furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods. To qualify as an LTACH for payment, a facility must meet Medicare's conditions of participation for acute care hospitals. Specialty hospitals classified as a LTACH are eligible for reimbursement for services that meet the definition at 42 CFR 440.10.

REIMBURSEMENT:

LTACH have a different hospital specific unit value but employs the major components and methods to determine reimbursement as acute care hospitals under this state plan Attachment 4.19-A, pages 7 through 11, 22 and 24-27:

- Diagnosis-Related Group (DRG);
- Medicare grouper;
- DRG relative weights (LTC not MS);
- case mix index;
- unit value;
- DRG payment;
- Cost outlier payments;
- Capital;
- Supplemental payments;
- Death occurring on day of admission;
- Hospital transfers;
- Third party resources;
- Upper payment limits;
- Disallowed payments;
- Appeals.

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SPECIALTY HOSPITALS: Long-term care hospitals (LTACH)(Cont)

REIMBURSEMENT (Cont):

LTACH reimbursement does not include the following components and methods that are included for acute care hospitals under this state plan Attachment 4.19-A, pages 13 through 21A-2:

- Graduate Medical Education (GIME & GDME);
- Disproportionate share payment.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, and medical social services furnished by the hospital.

Health Care Acquired Conditions (HCACs):

HCACs will be processed and paid in accordance with the State Plan standards for payment adjustment for provider preventable conditions, as established in Attachment 4.19-A, page 5 of this State Plan.

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General: The division pays the lesser of the usual and customary charge or a fee based on the methods outlined for the program according to Attachment 4.19-B. The provider's usual and customary fee is the fee charged by the provider to the general public for the particular service rendered.

Where applicable, the maximum allowable fees are established using the CMS Resource Based Relative Value (RBRVS) Scale methodology as published in the Federal Register annually, times an Oregon specific conversion factor. Except as otherwise noted in the plan, the agency's rates were set as of 1/1/22 and are effective for dates of services on or after that date. The reimbursement methods listed in this section of the plan are available on the agency's website <http://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>. State developed fee schedule rates are the same for both governmental and private providers.

Provider type/ Service type	Payment method
3. Laboratory and Radiology services	Clinical Laboratory and Pathology Procedures are paid at 70% of current Medicare fee updated annually as published by Medicare. Other lab and X-ray services are paid on a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.
5.a. Physician/Practitioner services, Physician Assistant, Physician/Practitioner Administered Drug 5.b. Medical and surgical services furnished by a dentist 6. a. Podiatrists' services 6. c. Chiropractors' services	Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor. Physician/Practitioner Administered Drugs is based on 100% of the Medicare fee schedule. When no Medicare fee schedule is listed the rate shall be based upon the Wholesale Acquisition Cost (WAC). If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Anesthetists' payment for services is a state-wide fee schedule which utilizes the current American Society of Anesthesiology Relative Value base units plus time.
5.a. Physician/Practitioner services for neonatal and pediatric intensive care CPT codes 99468-99480	Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.
6. b. Optometrist services Ophthalmologist, optometrists.	Exam and dispensing: Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.
6. d. Other Practitioner Services; Naturopath, Acupuncturist, Certified Nurse Practitioner and Licensed Direct Entry Midwives	Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.

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Reserved for future use

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6.d. Emergency Medical Technician (EMT), Advanced EMT (AEMT), EMT-Intermediate (EMT-I), Emergency Medical Responders (EMR), and Paramedics:

Payment for services is a state-wide fee schedule which utilizes CMS HCPCS codes, appropriate for their scope of practice, using a combination of fix rates and Medicare rates. Treat-in-place code A0998 is priced using the ALS1 Base Rate (A0427) of \$420.62. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 5/12/23 and is effective for services provided on or after that date. All rates are published on the agency's website <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>.

6.d. Nurse Anesthetists:

Payment for services is a state-wide fee schedule which utilizes the current American Society of Anesthesiology Relative Value base units plus time.

6.d. Board Certified Behavior Analyst:

Payment for services is based on a state-wide fee schedule. The fees were developed from a survey of other State Medicaid Programs. This rate is effective for dates of service on or after 7/1/22.

7. Home Health:

Payment for services is a state-wide fee schedule based upon 74% of the most recently accepted Medicare Cost reports.

7. c. Medical Supplies and Equipment:

Payment for services is a state-wide fee schedule. Rates are based on the following percentages of the 2012 Medicare fee schedule:

- Ostomy supplies are at 93.3%
- Rental rates on group 1 and 2 power wheelchairs with no added power options (K0820-K0829) are at 55%
- Complex Rehab items, other than power wheelchairs, are at 88%
- All other Medicare covered items/services are at 82.6%
- Unlisted procedures are based upon 75% of Manufacturer's Suggested Retail Price (MSRP). If MSRP is not available payment is acquisition cost plus 20%.

For new codes added by CMS, payment will be based on the most current Medicare fee schedule and will follow the same payment methodology as stated above. This rate is effective for dates of service on or after 2/1/14.

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8. Private Duty Nursing Services:

Payment for services is a state-wide fee schedule based on nursing market rate study's performed each biennium. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 7/1/23 and is effective for services provided on or after that date. All rates are published <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

10. Dental services (Dentist, Dental hygienist with an Expanded Practice Permit)

Payment for services is based on a state-wide fee schedule. The fees were developed from a survey of other State Medicaid Programs and the largest commercial dental insurance carrier in Oregon. This rate is effective for dates of service on or after 2/1/18 and can be accessed at <http://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>.

11. Physical Therapy, Occupational Therapy, Speech, Hearing, Audiology services

Payment for services is a state-wide fee schedule which Utilizes the RBRVS Scale, times the Oregon specific conversion factor.

12.b. Dentures, Denturist

Payment for services is based on a state-wide fee schedule. The fees were developed from a survey of other State Medicaid Programs and the largest commercial dental insurance carrier in Oregon.

12.c. Prosthetic Devices

Payment for services is a state-wide fee schedule based on 84.5% of 2010 Medicare fee schedule. Unlisted procedures are based upon 75% of Manufacturer's Suggested Retail Price (MSRP). For new codes added by CMS, payment will be based on the most current Medicare fee schedule and will follow the same payment methodology as stated above. This rate is effective for dates of service on or after 7/1/12.

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12.d. Eyeglasses, contacts and hardware

Payment for services is a state-wide fee schedule utilizing a contract with a federally qualified rehabilitation facility. The contract is effective for service on or after 10/1/11

24.a. Transportation

Payment for Emergency Transport and Non-emergency transports not provided/arranged by the brokerage system is a state-wide fee schedule.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 4/1/23 and is effective for services provided on or after that date. State-wide fee schedules are published on the agency web at: <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

Client and necessary attendant reimbursement:

Mileage rate- 75% of IRS standard rate and is all-inclusive.

Meal rate- 50% of the IRS standard rate for Breakfast, Lunch and Dinner.

Lodging rate- 100% of the IRS standard rate

Volunteer drivers: Rides are reimbursed per standard GSA mileage rates for business miles driven.

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24.f Personal Care Services:

For Clients Served through Seniors and People with Disabilities:

Payments are made to individual providers based on state-wide uniform hourly rate. The fee schedule is the same for both governmental and private providers. The rate for Personal Care Services for Clients Served through Seniors and People with Disabilities was last updated on 1/1/11 and is applicable to services rendered on or after that date. The rate is posted on the agency web at: <http://www.oregon.gov/DHS/spd/provtools/rateschedule.pdf>.

For Clients Served through the Addictions and Mental Health Divisions (AMH):

For services provided in licensed community-based residential treatment settings, which include residential treatment home/facility, secure residential treatment facility and Young adult in transition treatment home, OHA has developed a standardized rate based upon actuarially sound principles for personal care services tiered for different levels of client acuity needs in a range of bed size bands. The tiered rates are developed for the Oregon specific regions for annually adjusted minimum wage trended forward. The personal care service rates provided in these residential settings do not include reimbursement for room and board.

Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Oregon Health Authority with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

Retainer payments may be made to providers of personal care and habilitation while the individual is hospitalized or absent from the congregate setting for no more than 30-days, or as authorized by the agency. The retainer payment applies the standardized rate absent bed tier with no staffing or engagement costs during the temporary absence.

For services provided in non-licensed settings, eligible individuals may receive up to 20 hours of personal care services per month at state-wide uniform hourly rate

Current base rates are made available on the internet at:

<https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

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Provider type/ Service type	Payment method
24.f. Personal Care Services	<p><u>For Children in a Foster Care Setting:</u></p> <p>Payments are made to individual providers (in accordance with a fee schedule for personal care services maintained in Chapter 413 of the Oregon Administrative Rules) based on the special needs of an individual child, identified through an assessment performed by an Registered Nurse and incorporated into an individual plan of care. Payment is only made for the days the child is eligible for and receives personal care services. The fees were last updated September 1, 2009.</p> <p>There are four levels of care:</p> <ul style="list-style-type: none">Level 1 - \$47.77 per week;Level 2 - \$95.30 per week;Level 3 - \$143.07 per week; andLevel 4 - In extraordinary situations where continuous observation and/or interventions may be required, individualized rates are developed based on the child's needs.

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9. Clinic Services:

Free standing kidney centers :

Reimbursement for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) is provided under a statewide composite rate at 80% of the Medicare allowed amount published on January 1 of each year.

Epoetin is reimbursed at 100% of the Medicare maximum allowed amount published on January 1 of each year. Other dialysis related charges allowed by Medicare, are reimbursed at 80% of the Medicare maximum allowed amount published on January 1 of each year.

Allowable clinical laboratory charges are reimbursed according to Attachment 4.19-B, page 1 of this state plan. Billed charges may not exceed the Medicare maximum allowable amount.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate is effective for services provided on or after 1/1/2014. All rates are published on the agency web at: <http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx>.

Freestanding ambulatory surgery centers (ASC):

Reimbursement for select surgical procedures is provided under a statewide rate and is the lower of:

1. Submitted charges or
2. 80% of the Medicare rate published on January 1 of the prior fiscal year to be updated each year with the prior year's rate.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate is effective for services provided on or after 1/1/2014. All rates are published on the agency web at:

<http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx>

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9. Clinic Services: Indian Health Service and Tribal Health Facilities (I/T)

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.

The outpatient per visit rate is also known as the IHS encounter rate. The definition of an encounter is, "A face-to-face contact between a health care professional and an IHS beneficiary eligible for the Medical Assistance Program for the provision of Title XIX/CHIP defined services through an IHS, AI/AN Tribal Clinic or Health Center, or a Federally Qualified Health Clinic with a 638 designation within a 24-hour period ending at midnight, as documented in the client's medical record."

The outpatient per visit rate is paid for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services. This provision also applies to AI/AN Tribal Clinics or Health Centers with a 638 designation that utilize the Prospective Payment System (PPS) rate as outlined in Benefits Improvement and Protection Act (BIPA), Public Law 106-554 and Oregon Administrative Rule Chapter 410 Division 146.

Pharmacy encounters will be paid at the federal OMB clinic encounter rate as outlined in Attachment 4.19-B, section 12-prescribed drugs of this state plan.

The following provider types are allowable to be reimbursed under the IHS encounter rate: Physicians, Physician Assistants, Advanced Nurse Practitioners, Nurse Midwives, Dentists, Pharm D, Speech-Language Pathologist, Audiologist, Physical therapist, Occupational therapist, Podiatrist, Optometrist, Substance Use Disorder Counselors, Psychiatrist, Psychologist, Mental Health Professionals or other health care professionals including those professionals listed in this state plan Attachment 3.1-A, Section 6.d Other Practitioner Services.

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9. Clinic Services: Indian Health Service and Tribal Health Facilities (I/T)(Cont)

These services are not limited except as directed by the Oregon Administrative Rule -General Rules - Excluded Services and Limitations, the American Indian/Alaska Native Billing Guide and the Health Evidence Review Committee (HERC) Prioritized List of Health Services (List) as follows: Coverage for diagnostic services and treatment for those services funded on the HERC List and Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HERC List.

Medical Transportation services are outside the IHS encounter rate and are reimbursed under the OHA fee-for-service system.

Dental Service- Pay for Performance Supplemental Payment Program:

Pay for Performance Supplemental Payments for qualifying dental providers apply to IHS clinic dental services the same as described in this state plan Attachment 4.19-B, page 40-41.

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13.c. Preventive Services: Doula services

Effective for services on or after July 1, 2022, doula services provided during labor and delivery (includes antepartum and postpartum period) are reimbursed at the lower of:

1. Submitted charge; or
2. \$1500 per pregnancy, includes a minimum of 2 prenatal care visits, care during delivery and 2 postpartum home visits.

Doulas services can be billed once per pregnancy. Multiple births (i.e twins, triplets) are not eligible for additional reimbursement.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate is effective for services provided on or after 7/1/2022. All rates are published on the agency web at:
<http://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

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Preventive Services: Lactation Consultation services

OHA pays for Lactation Consultation services at the lower of:

1. The provider's submitted charge; or
2. The maximum allowable fee established by the Authority.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Lactation Consultation Services. The agency's fee schedule rate was set as of 4/1/20 and is effective for services provided on or after that date. All rates are published on the agency's website at <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

13.c Preventive Services: Newborn Nurse Home Visit

Newborn Nurse Home Visits

Reimbursement for **Newborn Nurse Home Visits** is provided under a statewide rate and is the lower of:

1. Submitted charges; or
2. 99502 with modifier 32 = \$592.81
99502 with modifier TD = \$242.31
99502 with modifier TT = \$170.65

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate is effective for services provided on or after 1/1/2022. All rates are published on the agency web at: <http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx>

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13.c. Preventive Services: Community Violence Prevention Services

Community violence prevention services will be billed under the following HCPCS code:
H2015-Comprehensive Community Support- \$99.12 per hour or \$24.78 per 15-minute increments.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of community violence prevention services. The agency's fee schedule rate is effective for services provided on or after 1/1/2023. All rates are published on the Oregon Health Authority, OHP website: <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

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13.d. Rehabilitative Mental Health Services

Payment methods for Rehabilitative Mental Health Services are a state-wide fee schedule effective for services provided on or after 7/1/22. The fee schedule is posted on the agency web at: <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of rehabilitative mental health services.

13.d. Rehabilitative Services: Substance Use Disorder (SUD)

Payment methods for Rehabilitative SUD Services are a state-wide fee schedule effective for services provided on or after 7/1/22. The fee schedule is posted on the agency web at: <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Rehabilitative SUD Services.

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20. Extended Services to Pregnant Women

Payment is based on a statewide fee schedule utilizing HCPCS procedure codes G9001-G9012 and S9470. The rate was established in 1989 utilizing cost of services, practitioner time and other factors as a base with legislative approved cost of living adjustments periodically since that time. The current state developed fee schedule rates are the same for both governmental and private providers and are effective for services provided on or after 7/1/2014. Fee schedule rates are posted on the agency web at: <http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx>.

4.b. EPSDT Services

Payment, as appropriate for the provider type and type of service, is pursuant to Attachment 4.19-A, 4.19-B, page 1, 1.a, 1.a.1,1-d,3, 5 through 17 of this state plan.

Targeted Case Management services reimbursement is as specified for the appropriate TCM service group in Attachment 4.19-B, page 4 through 4r.

Preventive Services for HIV Infected Individuals

Payment will be based on a statewide fee schedule.

TN # 95-004
SUPERSEDES
TN #

DATE APPROVED 6/13/95
EFFECTIVE DATE 1/1/95

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18. Hospice

Payment for hospice care is made to a designated hospice provider based on a daily rate. The rates are contingent on the type of service provided that day. The hospice payment base rates are calculated using the annual hospice rates established under Medicaid. These rates are authorized by section 1814(i)(1)(C)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services. These rates will be adjusted by applying the hospice wage index for the geographic locale in which the hospice services are provided.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website at <http://www.dhs.state.or.us/policy/healthplan/guides/hospice/main.html>.

The rates are effective each October, or as published in the Federal register by CMS.

Additional Amount for Nursing Facility Residents:

In accordance with the State Medicaid Manual at section 4308, the additional amount paid to the hospice on behalf of an individual residing in a nursing facility is equal to 100 percent of the per diem rate.

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Disease Management reimbursement methods:

The state contracts for DM services. The State will use a method of payment based on a cost per member calculation. The State expects services to be budget neutral.

Reimbursement Methodology for Rehabilitation Services Provided in Psychiatric Day Treatment Centers

Payment will be made to private, non-profit treatment agencies using individually negotiated daily or hourly rates for each facility, negotiated by the appropriate office.

Nurse Midwives

Payment for services by nurse midwives and other licensed nurse practitioners will be at the same level as for physicians and independent clinical labs.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is on a fee-for-service basis, with one day being the unit of service. Rates are set using a prospective staffing based rate model that uses data gathered by the State Department of Employment reporting the prevailing wages in the State of Oregon. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitation services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavior Rehabilitation Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards.

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

A. Local Education Agencies (LEAs) that elect to participate are reimbursed for certain health care services on a prior year audited cost basis. These services are:

1. Audiology Services
2. Behavioral Health Services
3. Dental Health Services
4. Diagnostic, screening, preventive, developmental and rehabilitative services
5. Nursing Services
6. Nurse Practitioner Services
7. Nutritional Health Services
8. Occupational Therapy Services
9. Personal Care Services
10. Physical Therapy Services
11. Physician Services
12. Respiratory Therapy Services
13. Specialized Transportation Services
14. Speech-Language pathology Services

All costs described within this methodology are for health care services provided by qualified personnel or qualified health care professionals who have been approved under Attachments 3.1-A and 3.1-B of the Medicaid State Plan.

LEAs in Oregon will be paid for the above listed services on a rate based on the previous year costs as described below for the following services, and updated annually based on the previous year's final audited cost reports per LEA:

- Medicaid eligible services identified in:
 - An Individualized Education Program (IEP);
 - An Individualized Family Service Plan (IFSP);
 - Other Medical Plans of Care:
 - A Section 504 plan;
 - Any other documented individualized health or behavioral health plan or as otherwise determined medically necessary otherwise.

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

B. Direct Medical Payment Methodology:

LEAs will be reimbursed on a cost basis using audited financial information from the Oregon Department of Education (ODE). The audits are performed annually by each LEA and reported to the ODE. Data Capture for the Cost of Providing Health-Related Services is the total direct and indirect costs captured utilizing the SBHS Medicaid Cost calculation worksheet received from each LEA. The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

C. Data Sources and Cost Finding Steps:

The following provides a description of the data sources and steps to complete the cost per service category.

1. Allowable Cost classifications:

Direct, Indirect, Excluded, and Unallowed costs

- Direct costs are those costs that can be identified or allocated specifically to a particular cost objective – For SBHS these cost objectives are the health-related service categories/disciplines specified on a child/students plan of care required by IDEA, the Rehabilitation Act of 1973, or are otherwise medically necessary.
- Indirect costs are costs that are identified as Common or joint purpose benefiting more than one cost objective and cannot be identified or allocated specifically to a particular cost objective for health-related services specified on a child/students plan of care leveraging Medicaid for SBHS.
- Unallowed Costs identified CANNOT be charged to federal awards & included only for purposes of ODE calculating the LEA's indirect rate
- Excluded Costs identified are Not included in ODE calculation of the LEA's indirect rate

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

a. Direct costs for direct medical services include unallocated payroll costs and other allocated costs attributable to a budgeted specific service category/discipline that can be directly charged to direct medical services using 2 CFR 200 Subpart E cost principals and 45 CFR 75 as implemented by HHS. Direct payroll costs include total compensation (salaries, benefits, and medical supplies and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs. These direct costs are calculated on a LEA-specific level. Costs for transportation personnel are reported as defined in Section E).

b. Indirect costs are determined by applying the specific LEAs Unrestricted Indirect Cost Rate (UICR) established for the current year by the cognizant federal agency. The Oregon Department of Education is the cognizant agency for LEAs and approves UICR cost rates. LEAs are not permitted to certify indirect costs that are outside their UICR. The indirect cost rate is calculated from costs that are not included in the allowable reported expenditures so there is no duplication of costs.

D. Calculation of Costs Associated with Direct Medical Services:

This is a cost-based methodology using previous year's settled cost reports to develop prospective rates for each LEA participating in the school-based services program on a per minute basis for each of the following school-based providers:

1. Audiology Services
2. Behavioral Health Services
3. Dental Health Services
4. Diagnostic, screening, preventive, developmental and rehabilitative services
5. Nursing Services
6. Nurse Practitioner Services
7. Nutritional Health Services
8. Occupational Therapy Services

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

9. Personal Care Services
10. Physical Therapy Services
11. Physician Services
12. Respiratory Therapy Services
13. Specialized Transportation Services
14. Speech-Language pathology Services

The cost-based rates are developed using 100% of the costs based on the previous year's final audited cost report.

The costs developed for the individual School-Based Health Services (SBHS) listed at (A) above is based on the financial data from each individual local education agency's (LEA) prior year, actual audited expenditures/costs for direct costs including: salaries, benefits, and medical supplies and indirect costs: using the UICR. The Oregon Department of Education (ODE) requires annual cost reporting for each individual LEA. These annual cost reports are used with the cost worksheets developed and approved by the Oregon Health Authority (OHA) for establishing each individual LEA's actual costs attributable to each service discipline. The Medicaid Cost Calculation worksheet is used to develop a cost per/minute for each type of Medically qualified staff (as listed above). Oregon utilizes each LEA's actual audited expenditures allocated to each service/discipline, captured using budget codes outlined in Oregon's Program Budget and Accounting Manual (PBAM) from the prior year required to be reported annually to the ODE by December 31st.

The source of this financial data is based on each LEA's annually ODE reported prior year audited expenditures incurred for each service category/discipline listed above and identified in accordance with ODE Program Budget Accounting Manual (PBAM) chart of accounts kept at the LEA level. The chart of accounts are accessible to auditors.

The ONLY costs/time billed to Medicaid are for those minutes where treatment is provided and supporting documentation for actual service time in minutes is completed and maintained for children/students who are enrolled Medicaid recipients under the plans of care described above. The cost computation includes only those costs directly attributable to SBHS per discipline are included.

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

Each LEA's per minute costs are established using the LEA's prior year audited costs reported annually to ODE and billed to Medicaid on a Fee-For-Service (FFS) basis and are kept by OHA Medicaid policy for monitoring and auditing purposes for the amount(s) billed by the LEA.

If an LEA does not have full prior year actual costs to establish a per minute rate for a SBHS discipline billable to Medicaid, they will use a cost methodology for the first year, until a cost-based rate can be established. The LEA may establish a rate based on actual costs expended in the current school fiscal (SFY) year.

The Oregon State Medicaid agency and any contractors used to help administer any part of the school-based services program are aware of federal regulations listed below for audits and documentation, and will provide documentation needed to support school-based services claims

- a. 42 CFR 431.107 Required provider agreement
- b. 45 CFR 447.202 Audits
- c. 45 CFR 75.302 Financial management and standards for financial management systems

E. Specialized Transportation Services Payment Methodology

- A. LEAs will be reimbursed for specialized transportation services on a cost-based reimbursement methodology per 1-way trip using the Medicaid SBHS Cost Calculation Worksheet. Costs are determined utilizing the following factors: total cost of special education transportation determined by the direct costs (as described in section B, below), the application of the UICR, the percentage of Medicaid enrolled students receiving specialized transportation on their IEP/IFSP from the total IDEA students receiving specialized transportation on their IEP/IFSP, and the total number of Medicaid IDEA specialized transportation IEP/IFSP one-way trips. (All special education transportation costs utilized, are prior year actual audited expenditures/costs and are not regular education costs).

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

- 1) Specialized transportation is specifically listed in the IEP/IFSP as a required service;
- 2) The child requires specialized transportation in a vehicle adapted to serve the needs of an individual with a disability;
- 3) A Medicaid eligible service is provided on the day that the specialized transportation is billed; and
- 4) The service billed only represents one-way trip(s) for specialized transportation for a Direct Medical Service listed in the IEP/IFSP.

B. Transportation costs included on the SBHS Cost Calculation worksheet will only include those personnel and non-personnel costs associated with specialized transportation. The Cost Calculation worksheet includes the following direct costs:

1. Bus Drivers/Aides
2. Mechanics/Mechanic Assistant
3. Substitute Drivers
4. Fuel/Oil
5. Repairs & Maintenance
6. Lease/Rentals
7. Insurance Costs
8. Contracted Professional Transportation Services and/or Equipment
9. Depreciation of specialized transportation equipment >\$5000

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4.b. EPSDT- School-Based Health Services cost based methodology for services provided by local education agencies (LEA).

In the rare instance, that an LEA does not have previous year transportation trip logs to determine the number of actual one-way trips required to determine the denominator in the transportation cost methodology, the LEA must use the most conservative method for identifying the total number of possible one-way trips. This conservative alternate trip computation may be used once only and is as follows: Multiply the total number of IDEA Medicaid enrolled students with medically necessary transportation specified on their IEP plan by the maximum total number of school days in session multiplied by 2 daily trips to determine the total number of trips.

Example: 20 Medicaid enrolled students w/Medically necessary transportation on their IEP x 170 calendar school days x 2 trips per day (from home to place of Medicaid covered service and from place of service to home) = 6800 total trips

The source of this financial data is based on each LEA's prior year audited expenditures incurred for specialized transportation and identified in accordance with ODE Program Budget Accounting Manual (PBAM) chart of accounts kept at the LEA level and reported to the Oregon Department of Education annually.

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12. Prescribed Drugs

A. General

- (1) The Oregon Health Authority, Medical Assistance Program will pay the lesser of the provider's usual charge to the general public for a drug or the actual acquisition cost (AAC) plus a dispensing fee. The AAC is defined by the Authority as :
 - a. The Oregon-specific Average Acquisition Cost (OR-AAC) of the drug. The OR-AAC will be established by the Authority or its contractor by rolling surveys of enrolled pharmacies to verify the actual invoice amount paid by the pharmacy for the product and as such will serve as the basis for reimbursement;
 - b. In cases where no OR-AAC is available, reimbursement will be at the National Average Drug Acquisition Cost (NADAC) developed by CMS;
 - c. In cases where no OR-AAC and no NADAC is available, reimbursement will be Wholesale Acquisition Cost (WAC) ;

B. Payment Limits for Single and Multiple Source Drugs

- (1) Reimbursement for single source and multiple source drugs in the Medicaid Program shall follow the methodology outlined in section A.(1) of this state plan attachment.
 - a.
- (2) The maximum allowable cost set by the Authority for multiple source drugs will not exceed, in aggregate, the upper limits established under 42 CFR 447.512.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

C. Payment Limits for 340B entity:

- (1) 340B covered entity pharmacies who carve in for Medicaid, shall not exceed the entity's actual acquisition cost, plus the assigned professional dispensing fee.
- (2) 340B covered entities that purchase drugs outside of the 340B program are reimbursed at the AAC rate defined in section A. (1) of this state plan attachment, plus the usual professional dispensing fee.
- (3) Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.
- (4) The professional dispensing fee allowed for a 340B covered entity is the same as for any enrolled pharmacy, according to claims volume as outlined in section J of this state plan.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

D. Indian Health Service/Tribal (I/T) Pharmacy:

An eligible I/T pharmacy may choose to participate in the Medicaid Program and receive reimbursement for Medicaid covered services under any of following options:

- (1) I/T Pharmacy will receive reimbursement as a 340B entity outlined in this State Plan attachment section C (1) through (4);
- (2) I/T pharmacy will receive the Indian Health Service (IHS) per visit outpatient encounter rate, called the All-Inclusive Rate (AIR). Under an encounter rate methodology, a single rate is be applied to "A face-to-face contact between a health care professional and an IHS beneficiary eligible for the Medical Assistance Program for services through an IHS, AI/AN Tribal Clinic or Health Center, or a Federally Qualified Health Clinic with a 638 designation within a 24-hour period ending at midnight, as documented in the client's medical record. The I/T Pharmacy will receive one encounter per prescription filled or refilled and will not be limited to a certain number of prescriptions per day.
- (3) I/T Pharmacy operating as a non tribal retail pharmacy will receive reimbursement as outlined in Attachment 4.19-B of this state plan, section 12.A.

- E. Pharmacies who purchase drugs at Nominal Price (outside of 340B or FSS) will be reimbursed their actual acquisition cost plus the usual professional dispensing fee.
- F. Pharmacies who purchase drugs at the Federal Supply Schedule will be reimbursed their actual acquisition cost plus the usual professional dispensing fee.
- G. Specialty Drugs (Not distributed by a Retail Pharmacy and distributed primarily through the Mail): The Authority reimburses at the AAC rate defined in this state plan attachment, plus the usual professional dispensing fee.
- H. Long-Term Care Pharmacy: The Authority reimburses at the AAC rate defined in this state plan, plus the usual professional dispensing fee.

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12. Prescribed Drugs (continued)

- I. Physician/Practitioner Administered Drugs: reimbursement is based on 100% of the Medicare fee schedule. When no Medicare fee is listed the rate shall be based upon the Wholesale Acquisition Cost (WAC). If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. 340B covered entities that bill for Physician/Practitioner Administered Drugs and carve in for Medicaid, shall not exceed the entity's actual acquisition cost.
- J. Investigational Drugs – Investigational drugs are not a covered service under the Oregon Medical Assistance pharmacy program.
- K. Clotting Factor from Specialty Pharmacies: OHA utilizes in-state Federally Qualified Hemophilia Treatment Centers of Excellence for clotting factor payments for patients without Medicare or third-party liability (TPL) coverage. Reimbursement is at the Public Health Service (PHS) 340B rate on an outpatient hospital UB-04 claim transaction. Reimbursement for clotting factor payments outside of Centers of Excellence is in accordance with section 12(A)(1) of this state plan.

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12. Prescribed Drugs (continued)

L. Professional Dispensing Fees

- (1) The Authority establishes professional dispensing fee payments based on the survey results of pharmacies. The professional dispensing fee structure will be one of 3 rate tiers. The Authority or its designated representative will conduct an annual survey of every enrolled pharmacy to determine which tier the pharmacy will be paid.
- (2) Based upon the annual volume of the enrolled pharmacy, the professional dispensing fee will be as follows:
 - Low volume pharmacies (Less than 30,000 claims a year) = \$14.30
 - Mid volume pharmacies- (30,000 and 69,999 claims per year) = \$11.91
 - High volume pharmacies (70,000 or more claims per year) = \$ 9.80
- (3) Pharmacies that fail to respond to the annual survey will default to the highest volume tier dispensing fee.
- (4) Pharmacies dispensing through a unit dose or 30-day card system must bill OHA only one dispensing fee per medication dispensed in a 30-day period.
- (5) Professional dispensing fee tiers are applicable to all pharmacies: retail independent, Institutional, mail order, compounding and 340B programs.
- (6) Retail chain affiliated pharmacies with 10 or more stores shall be reimbursed at the lowest tier regardless of volume.
- (7) Independently owned pharmacies in communities that are the only enrolled pharmacy within a fifteen (15) mile radius from another pharmacy shall be reimbursed at the lowest volume tier regardless of volume.
- (8) All 340B pharmacies operated by a 340B covered entity shall be reimbursed at the lowest volume tier regardless of volume.

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Child Welfare and Oregon Youth Authority

Targeted Case Management (TCM) services provided to Medicaid recipients under age 21 who are currently residing in an in-home setting; a foster home; group home; residential care facility (excludes Institutions for Mental Disease and Public Institutions as defined in 42 CFR 435.1010); or independent living situation under the responsibility of the Children, Adults and Families division of the Department of Human Services (DHS) or the Oregon Youth Authority (OYA) are delivered by DHS employed case workers or OYA employed parole and probation officers (herein after referred to as “providers” for this section of the State Plan).

Reimbursement Methodology

Claiming is based on the actual cost of providing the TCM service as determined using a federally approved Random Moment Time Study (RMTS) and Public Assistance Cost Allocation Plan (PACAP). The RMTS is used to determine what portion of the provider’s time is spent performing covered TCM activities. The percentage of time is applied to a “cost pool”, limited to TCM providers, in the PACAP to determine the cost of providing the TCM service. All qualified providers are included in the sample universe for the HHS-approved time study and only providers identified in the approved State plan may be included in the cost pool for the time study.

Cost Allocation is used by DHS and OYA to determine appropriate claiming of federal and other funding sources for all benefiting programs.

The total direct and indirect cost of providing TCM services, as determined by RMTS and Cost Allocation, is reported on the CMS-64 Quarterly Expense Report.

Data Capture for the Cost of Providing TCM Services

Data capture to determine the total direct and indirect cost of providing TCM services will be captured utilizing the data sources listed below:

1. TCM services quarterly cost report from OYA;
2. Random Moment Time Study (RMTS) Activity Codes provided in Appendix C, Part D, Section 3 of the State’s approved Public Assistance Cost Allocation Plan; and

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Child Welfare and Oregon Youth Authority (Continued)

3. The percentage of time spent on covered TCM activities as determined by the RMTS, applied to the approved PACAP to determine the applicable indirect portion.

Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs:

Direct costs for TCM services include unallocated payroll costs and other unallocated costs that can be directly charged for TCM services. Unallocated costs are those expenses that are assigned to one single cost objective in the cost allocation plan. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation). These direct costs will be calculated on a provider-specific level and are determined using an approved RMTS to determine the percentage of time spent providing covered TCM activities. Other direct costs include costs directly related to the approved direct services personnel for the delivery of TCM services, such as services, supplies and materials. Appendix C, Part E of the State's PACAP contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the provider level. The Chart of Accounts is uniform throughout the state of Oregon. Costs will be reported on an accrual basis.

2. Indirect Costs:

Indirect costs are determined by applying the approved indirect percentage to the adjusted direct costs. The indirect cost rate percentage is an amount that comes from the federally approved rate agreement on file with the federal HHS Cost Allocation Services.

3. Time Study Percentages:

A CMS-approved time study is used to determine the percentage of time that personnel spend providing covered TCM activities, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results will be applied to the TCM services cost pool. The TCM services costs and time study results must be aligned to ensure proper cost allocation. The use of CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per OMB Circular A-87 cost allocation requirements.

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Child Welfare and Oregon Youth Authority (Continued)

4. Total Medicaid Reimbursable Cost:

The result of the previous steps will be a total Medicaid reimbursable cost for each provider for Targeted Case Management services.

5. Cost Settlement:

Claims paid during the previous 12 months/reporting period, as documented in MMIS and in the Cost Allocation Plan, will be compared to the total Medicaid allowable cost for targeted case management services delivered by OYA according to the methodology described in this attachment. Any amounts due to or from the State Medicaid Agency will be adjusted in the aggregate, which results in cost reconciliation. Reconciliation will occur within 24 months of the last day of the reporting period. If it is determined that an overpayment has been made, the State will return the federal share of the overpayment. If the actual certified Medicaid allowable costs of targeted case management services delivered by the sister state agency exceed the amounts which have already been claimed during the reporting period, the State will submit claims to CMS for the underpayment. The State will not modify the scope of costs, time study methodology or the annual cost reporting methodology without CMS approval.

6. Audit:

All supporting accounting records, statistical data and all other records related to the provision of the targeted case management services delivered by OYA is subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted by OYA, the Oregon Health Authority's Medicaid payment rate for the said period is subject to adjustment.

Documentation and Reporting of Cost

DHS and OYA recognize the TCM services provided via this amendment on a monthly basis. In addition, these costs are claimed quarterly on the CMS-64.

Payment Methodology for Targeted Case Management for Persons with HIV Disease

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

The fee schedule developed for the Targeted Case Management is designed for specific tasks related exclusively to case management functions for this target group. The fee schedule is constructed by using the market value of the individual's time (the Bureau of Labor Statistics wage level) augmented by a margin for Program Related expenditures (supervisory staff, transportation, program supplies etc.), Employment Related expenditures (mandated and other benefits), and General and Administrative (Indirect). The assumptions from which the fees are developed are expressed in the service standards, and the fees are predicated on fifteen minute increments.

The program intends to establish and maintain a maximum number of fifteen minute increments which can be performed and billed for any single day. This maximum will be twenty four units (24 fifteen minute increments) in any given calendar day (midnight to midnight) which corresponds to an assumption that no more than six hours would ever be provided for the same client, by the same case manager in any twenty four hour calendar day.

The program will be utilizing an authorization methodology to monitor and control for this utilization limit.

The agency's rates were established as of 04/01/2008 and are effective for services on or after that date. All rates are published on the Agency's website.

State developed fee schedule rates are the same for governmental and private providers of HIV/AIDS Targeted Case Management services and the fee schedule and any annual/periodic adjustments to the fee schedule.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management-EI/ECSE

The cost based rate developed for EI/ECSE Targeted Case management is based on the Oregon Department of Education (ODE) EI/ECSE contractor's or subcontractor's prior year audited costs reported to ODE annually and reviewed and accepted by the Division of Medical Assistance Program for activities related exclusively to the provision of EI/ECSE Targeted Case Management services. Such services are provided by Service Coordinators/Targeted Case Managers furnished to children with disabilities in the target group, eligible under the State Plan, to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services in conjunction with the child's Individualized Family Service Plan (IFSP). An ODE EI/ ECSE contractor or subcontractor shall not bill for more hourly units than that of which was used to establish the costs which have previously been reviewed and accepted by the Division. The ODE EI/ECSE contractor or subcontractor's established hourly cost based rate is divided by 60 and yields a per minute cost amount. The per minute cost amount multiplied by actual number of minutes for services provided results in the ODE EI/ECSE contractor subcontractor's billing Medicaid no more than their cost to provide these services. If applicable, a finalized indirect rate established for the current year and approved by the cognizant federal agency delegate, Oregon Department of Education, may be applied, provided the costs included in the indirect cost calculation are not also included elsewhere in the calculation of the hourly cost based rate. As the above methodology utilizes cost based rates which are based on prior year costs, there will not be any need for reconciliation nor annual cost settlement required for payment made for TCM services provided by each ODE EI/ECSE contractor or subcontractor.

If the ODE EI/ECSE contractor or subcontractor does not have a full prior year cost to establish a TCM cost based rate, an estimate can be established based on the lesser of budgeted costs for the current year or an estimate of actual costs expended during the current year which prorates cost to the end of that year, however the Division will not require that a cost reconciliation be completed at the end of the year for ODE EI/ECSE contractor or subcontractor cost based rates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management-EI/ECSE

The ODE EI/ECSE contractor or subcontractor targeted case management cost based rate will be derived by considering the following expenditures directly attributable to Targeted Case Management Staff:

- Targeted case management staff salaries and other personnel expenses
- Supervisory salaries and other personnel expenses
- Administrative support salaries and other personnel expenses: Services and supply expenses
- Various Overhead expenditures, if not already considered in the Oregon Department of Education's indirect rate

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Methodology for Targeted Case Management for individuals with Substance Use Disorder

Payment for Medicaid eligible individuals in the target group will be based on 15 minute units of service with a maximum of sixteen (16) units per month. Billing providers will document the scope, frequency and duration of services;

Rates will be developed using a market based payment methodology utilizing statewide usual and customary data for case management services currently in effect prior to the implementation date of this amendment. The rates utilized are the same for private and governmental providers. Rates are reviewed at least every two (2) years for approved cost of living adjustments authorized by the Oregon Legislative.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Rehabilitative SUD Services. Payment methods are a state-wide fee schedule effective for services provided on or after 1/1/22. Statewide fee schedule rates and any annual/periodic adjustments to those rates will be published on the Department's website.

All services will be documented as required by Oregon Administrative Rule and/or Department procedure. Providers of targeted case management services will submit a CMS 1500 form to the Department's Medicaid Management Information System (MMIS) detailing the encounter as follows:

Date of Service
Name of Individual
Performing Provider Information
Procedure Code
Units of Service
Place of Service
U&C Charge

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management-Tribal members

The cost based rate developed for Tribal Targeted Case Management is based on the Tribes' prior year costs. Services are provided by the Tribe to enroll Tribal members, eligible under the State Plan, to assist the client to gain access to needed medical, social, educational, developmental and other appropriate services in conjunction with an individualized assessment.

"Unit" is defined as a week. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process.

The rate will be based on the Tribes cost of providing the service. The rate will be derived through a formula which divides the provider's costs of providing targeted case management, as determined by the State Medicaid agency, by the number of clients served. Tribal targeted case management costs, directed and related indirect costs, that are paid by other federal or state programs will be removed from the cost pool. The cost pool will be updated at a minimum, on an annual basis using provider cost report. A cost report must be submitted to the Department at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the following fiscal year.

The total cost of providing targeted case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses in support of TCM services; and
- Indirect expenses (General government service charges, worker's comp, property insurance, etc).

TCM services provided by IHS/638 facilities to Tribal (American Indian/Alaska Native) members will be claimed at 100% Federal Medical Assistance Percentage (FMAP) rate.

TCM services provided by IHS/638 facilities to non-Tribal (American Indian/Alaska Native) members will be claimed at the applicable direct medical services FMAP rate.

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Targeted Case Management-Public Health Nurse Home Visiting, Expanded Babies First CaCoon and Nurse-Family Partnership

“Unit” is defined as one encounter per visit. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process. Case management providers are paid on a unit-of-service basis that does not exceed 1 unit (encounter) per day.

The rate for reimbursement of the case management services is computed as follows:

<u>Compute the</u>	Total Annual Medicaid Encounters
<u>Compute the</u>	Total Annual Program Expenditures
<u>Divide</u>	Calculate Average Cost Per Encounter
<u>Examine</u>	Extreme values, develop “reasonable range”
<u>Equals</u>	AVERAGE COST PER ENCOUNTER

The total annual expenditures of providing targeted case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses;
- Administrative support salary and other personnel expenses;
- Services and supply expenses; and
- Expenses (General government service charges, worker’s comp, property insurance, etc).

The Agency’s rates are statewide rates, both public and private provider receive the same rate. The rates are set as of 1/1/20 and are effective for services on or after that date. All rates are published on the Agency’s website at <http://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Methodology for Targeted Case Management for Persons with Developmental Disabilities Comp waiver services.

Waiver Case Management (WCM) through the 1915(b)(4) -DD waiver replaces this State Plan Amendment for Targeted Case Management effective 7/1/13.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Methodology for Targeted Case Management for Persons with Developmental Disabilities Accessing Support Services.

Waiver Case Management (WCM) through the 1915(b)(4) -DD waiver replaces this State Plan Amendment for Targeted Case Management effective 7/1/13.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management for Children, Adults and Families Self sufficiency

Targeted Case Management (TCM) services provided to Medicaid eligible parents age 14 and over who receive Temporary Assistance to Needy Families (TANF) benefits are delivered by DHS employed case managers (herein after referred to as “providers” for this section of the State Plan).

Reimbursement Methodology:

Claiming is based on the actual cost of providing the TCM service as determined using a federally approved Random Moment Time Study (RMTS) and Public Assistance Cost Allocation Plan (PACAP). The RMTS is used to determine what portion of the provider’s time is spent performing covered TCM activities. The percentage of time is applied to a “cost pool”, limited to TCM providers, in the PACAP to determine the cost of providing the TCM service. All qualified providers are included in the sample universe for the HHS-approved time study and only providers identified in the approved State plan may be included in the cost pool for the time study.

Cost Allocation is used by DHS to determine appropriate claiming of federal and other funding sources for all benefiting programs.

The total direct and indirect cost of providing TCM services, as determined by RMTS and Cost Allocation, is reported on the CMS-64 Quarterly Expense Report.

Data Capture for the Cost of Providing TCM Services:

Data capture to determine the total direct and indirect cost of providing TCM services will be captured utilizing the data sources listed below:

4. Random Moment Time Study (RMTS) activity codes provided in Appendix C, Part D, Section 4, of the State’s approved Public Assistance Cost Allocation Plan; and
5. The percentage of time spent on covered TCM activities as determined by the RMTS, applied to the approved PACAP to determine the applicable indirect portion.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

TCM- CAF Self sufficiency

Data Sources and Cost Finding Steps:

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

3. Allowable Costs

Direct costs for TCM services include unallocated payroll costs and other unallocated costs that can be directly charged for TCM services. Unallocated costs are those expenses that are assigned to one single cost objective in the cost allocation plan. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation). These direct costs will be calculated on a provider-specific level and are determined using an approved RMTS to determine the percentage of time spent providing covered TCM activities. Other direct costs include costs directly related to the approved direct services personnel for the delivery of TCM services, such as services, supplies and materials. Appendix C, Part E of the State's PACAP contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the provider level. The Chart of Accounts is uniform throughout the state of Oregon. Costs will be reported on an accrual basis.

4. Indirect Costs

Indirect costs are determined by applying the approved indirect percentage to the adjusted direct costs. The indirect cost rate percentage is an amount that comes from the federally approved rate agreement on file with the federal HHS Cost Allocation Services.

3. Time Study Percentages

A CMS-approved time study is used to determine the percentage of time that personnel spend providing covered TCM activities, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results will be applied to the TCM services cost pool. The TCM services costs and time study results must be aligned to ensure proper cost allocation. The use of CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per OMB Circular A-87 cost allocation requirements.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

TCM- CAF Self sufficiency

5. Total Medicaid Reimbursable Cost

The result of the previous steps will be a total Medicaid reimbursable cost for each provider for Targeted Case Management services.

5. Cost Settlement:

Claims paid during the previous 12 months/reporting period, as documented in MMIS and in the Cost Allocation Plan, will be compared to the total Medicaid allowable cost for targeted case management services delivered by DHS according to the methodology described in this attachment. Any amounts due to or from the State Medicaid Agency will be adjusted in the aggregate, which results in cost reconciliation. Reconciliation will occur within 24 months of the last day of the reporting period. If it is determined that an overpayment has been made, the State will return the federal share of the overpayment. If the actual certified Medicaid allowable costs of targeted case management services delivered by the sister state agency exceed the amounts which have already been claimed during the reporting period, the State will submit claims to CMS for the underpayment. The State will not modify the scope of costs, time study methodology or the annual cost reporting methodology without CMS approval.

6. Audit:

All supporting accounting records, statistical data and all other records related to the provision of the targeted case management services delivered by DHS is subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted by DHS, the Oregon Health Authority's Medicaid payment rate for the said period is subject to adjustment.

Documentation and Reporting of Cost

DHS recognize the TCM services provided via this amendment on a monthly basis. In addition, these costs are claimed quarterly on the CMS-64.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management- Healthy Homes Program

The fee schedule developed for the Targeted Case Management is designed for specific tasks related exclusively to case management functions for this target group. It will be constructed based on the submitted direct and indirect costs of rendering allowable case management services.

Case management providers are paid on a unit-of-service basis that does not exceed one unit (encounter) per day per client. Documentation must be maintained for each encounter provided on each day. A unit is defined as one encounter per visit. A unit consists of at least one documented contact (face to face or by telephone) with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process. The number of visits per child is not limited but is based on the completion of the program.

The rate will be based on the cost of providing the service. The rate will be derived by the State Medicaid agency through a formula which divides the provider's costs of providing targeted case management by the number of clients served. Healthy Homes targeted case management direct or related indirect costs that are paid by other federal or state programs will be removed from the cost pool. The cost pool will be updated at a minimum, on an annual basis using provider cost report. A cost report must be submitted to the State Medicaid agency at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the following year.

The total cost of providing targeted case management includes:

- Targeted case management staff and other personnel expenses;
- Supervisory salary and personnel expenses in support of TCM services;
- Other direct costs in support of providing targeted case management
- Indirect costs from a rate approved by the federal Dept. of Health and Human Services not exceeding 10%.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management- Healthy Homes Program

Targeted case management expenses are aggregated within a cost object established in the provider's enterprise wide accounting system. All costs are allocated to the cost object in accordance with OMB A-87 and provider and department administrative rules and procedures. Indirect costs are allocated to the target case management program using the federally approved rate.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of case management for children with poorly controlled asthma or a history of environmentally induced respiratory distress and the fee schedule and any annual/periodic adjustments to the fee schedule are published in <http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/main.html>. The agency's fee schedule rate was set as of 7/1/2010 and is effective for services provided on or after that date. All rates are published on the agency's website.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management
Family Connect® Nurse Home Visiting

Family Connect® Nurse Home Visiting TCM will be paid at the Targeted Case Management-Maternal and Child Health Public Health Nurse Home Visiting, Babies First!, CaCoon, Nurse-Family Partnership® rate as outlined in Attachment 4.19-B, Page 4i of this state plan.

TN 19-0003

Approval Date: 9/18/19

Effective Date: 07/01/19

Supersedes TN NEW

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State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES

Oregon Type A and Type B hospitals are reimbursed for outpatient hospital services under a cost-based methodology. Interim payment is made by applying the cost-to-charge ratio, derived from the Medicare cost report, to billed charges for outpatient hospital services. A cost settlement based on the Medicare cost report, as finalized by the fiscal intermediary for purposes of Medicare reimbursement for the respective cost reporting period. The final reimbursement for Type A and Type B hospitals is at 100% of costs.

Oregon non-Type A and non-Type B hospitals (also referred to as DRG hospitals) are reimbursed for outpatient hospital services based on the most recent Medicare payment methodology established by the Centers for Medicare and Medicaid Services under the Outpatient Prospective Payment System using the Ambulatory Payment Classification (APC) methodology.

The APC methodology as described above does not apply to clinical laboratory services. The interim payment for clinical laboratory is the lesser of billed charges or the DMAP fee schedule as authorized in Attachment 4.19-B, page 1 of this state plan.

In addition, supplemental payments are made to non-Type A and non-Type B hospitals in an amount equal to the available gap under the applicable upper payment limit. In no instance will these payments exceed the available applicable gap. For private hospitals, payments will be limited to the total available private hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total private DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each private DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual private DRG hospital outpatient supplemental payments. This process will be repeated and payments will be made quarterly.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)

For non-state government owned hospitals, payments will be limited to the total available non-state government owned hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total non-state government owned DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each non-state government owned DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual non-state government owned DRG hospital outpatient supplemental payments. This process will be repeated and payments will be made quarterly.

Out-of-state hospitals are reimbursed at 50% of billed charges for all outpatient services except for clinical laboratory which are reimbursed at the lesser of billed charges or the DMAP fee schedule. There is no cost settlement.

Highly specialized out-of-state outpatient services are provided by written agreement or contract between DMAP and the provider. The rate is negotiated on a provider-by-provider basis and is a discounted rate.

Outpatient reimbursement does not exceed applicable Federal upper payment limits.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)

OUTPATIENT UPPER PAYMENT LIMIT CALCULATION

The following describes the steps followed in calculating the Medicare outpatient upper payment limit for Oregon. The data in this calculation comes from the most recently filed Medicare cost reports for each hospital and the corresponding Medicaid MMIS data.

1. The following Medicare costs were summed:
 - Worksheet D Part V column 9 line 104
 - Worksheet D Part V column 9.01 line 104
 - Worksheet D Part V column 9.02 line 104
 - Worksheet D Part V column 9.03 line 104

2. The following Medicare charges were summed:
 - Worksheet D Part V column 5 line 104
 - Worksheet D Part V column 5.01 line 104
 - Worksheet D Part V column 5.02 line 104
 - Worksheet D Part V column 5.03 line 104

3. The total Medicare costs in 1. were then divided by the total Medicare charges in 2. to establish the CCR

4. Medicaid charges and payments were extracted from Medicaid data

5. Medicaid charges were multiplied by the CCR in 3. to establish estimated Medicaid costs

7. Medicaid payments for fiscal year 2010 were then subtracted to find the outpatient upper payment limit gap for the all hospitals. Gaps across the non-state government owned, and private classes of hospitals were summed separately across classes to establish the aggregate upper payment limit gap for each class.

FQHC and RHC

A. Reimbursement for FQHC

For dates of service on or after January 1, 2001, payment for FQHC services will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554.

This payment is set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during the center's fiscal year 2001. These costs are divided by the total number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in the center's fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per visit basis) equal to the amount paid in the previous center's fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The center is responsible for supplying the needed documentation to the State regarding increases or decreases in the center's scope of services. The per visit payment rate shall include costs of all Medicaid covered services.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively cost settle FQHCs to the effective date of January 1, 2001, according to the BIPA 2000 requirements.

In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made no less frequently than every 4 months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

For newly qualified FQHCs after the center's fiscal year 2000, initial payments are established based on payments to the nearest center with a similar caseload, or in the absence of such center, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

B. Reimbursement for RHC

For dates of service on or after January 1, 2001, payment for Rural Health Clinic services will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554 .

This payment is set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the total number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in the clinic's fiscal year 2002, and for each fiscal year thereafter, each clinic is paid the amount (on a per visit basis) equal to the amount paid in the previous clinic's fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the clinic during that fiscal year. The clinic is responsible for supplying the needed documentation to the State regarding increases or decreases in the clinic's scope of services. The per visit payment rate shall include costs of all Medicaid covered services.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively cost settle RHCs to the effective date of January 1, 2001, according to the BIPA 2000 requirements.

In the case of any RHC that contracts with a managed care organization, supplemental payments will be made no less frequently than every 4 months to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

For newly qualified RHCs after the clinic's fiscal year 2000, initial payments are established based on payments to the nearest clinic with a similar caseload, or in the absence of such clinic, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics and adjustment for any increase/decrease in the scope of services furnished by the clinic during that fiscal year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Reimbursement for Independent Rural Health Clinic Obstetrics Care and Delivery Procedures

The Alternative Payment Methodology (APM) for obstetrics delivery procedures to eligible Medicare-certified Independent RHCs shall cease as of 5/1/2010.

As of 5/1/2010 reimbursement for obstetrics delivery procedures will be made in accordance with the physician fee schedule detailed on page 1 of this attachment.

TN No.: 10-06

Approval Date: 7/21/10

Effective Date: 5/1/10

Supersedes TN No. 05-02

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State: OREGON
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FQHC & RHC Alternate Payment Methodology

Payments to FQHCs & RHC will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. The APM will be effective on or after the date the clinic has signed an agreement with the Division. Those FQHCs & RHCs that do not choose the APM will continue to be paid under the Prospective Payment System (PPS) methods.

The APM will convert the clinic's current PPS rate into an equivalent Per Member Per Month (PMPM) rate using historical patient utilization and the medical only cost base rate for the specific clinic. The base rate is determined as illustrated:

- If a clinic PPS rate = \$100/medical encounter ;
- The clinic served 5000 Medicaid patients at an average of 3.0 encounters/patient, for total Medicaid medical visit revenue of \$1,500,000 (excluding dental and mental health revenue).
- APM rate is based on \$ 1,500,000 / 5000 = \$300 per patient, per year.
- The clinic's PMPM: \$300/12 = \$25 PMPM.

The conversion of the clinic's PPS rate to a PMPM includes estimates of the number of Fee-For-Service beneficiaries that will be served by the clinic as well as the average number of encounters/visits that will be delivered.

The APM will be adjusted annually by the MEI as published in the Federal Register.

The interim PMPM rate is not actuarially certified as it pertains to the FFS population and may not result in final payment to the center.

On a quarterly basis, these estimates will be reconciled to actual utilization data in order to monitor whether the payments will be in accordance with section 1902(bb) of the Social Security Act. To ensure that the appropriate amounts are being paid to each center, the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A).

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FQHC & RHC Alternate Payment Methodology

Utilization data will be pulled two quarters after the end of the year and analysis performed to determine the aggregate difference between the interim PMPM and the PPS for all FQHC & RHC services rendered within the clinic. Any enhanced payments needing to be made to bring total payments to a sum no less than the sum that would have been paid on PPS will be remitted within 120 days of the end of the year.

An adjustment will be made to a center's encounter rate if the center can show that they have experienced a valid change in scope of service. A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. As outlined in OAR 410-147-0362 a change in the scope of service will occur if: (1) the center adds, drops or expands any service that meets the definition of FQHC & RHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment.

For clients enrolled with a managed care contractor, the State will pay the center a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FQHC & RHC Alternate Payment Methodology

Tribal Clinics:

AI/AN Tribal Clinics with a 638 designation that are enrolled as a Federally Qualified Health Center may be paid an Alternative Payment Methodology (APM) for FQHC services that is equivalent to the Indian Health Service MOU rate, published annually in the Federal Register. Each individual tribal FQHC must agree to the APM, and the amount paid under this APM is at least equal to the Prospective Payment System (PPS) rate.

TN No. 23-0021

Approval Date: 8/1/23

Effective Date: 5/12/23

Supersedes TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

29. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Freestanding Birthing Centers are reimbursed a flat fee. The fee was developed by reviewing other like Medicaid states and Medicaid fees for similar services. The birthing center fee is the same for all birthing centers enrolled with the Division. The fee is a global rate based upon the procedure code for the service. Global rates include: Nursing services, services of technical personnel, and other related services; Any support services provided by personnel employed by the Birthing Center; the client's use of the facilities including the operating room and recovery room; Drugs, biologicals, surgical dressings, supplies, and equipment related to the provision of the procedure(s); Diagnostic or therapeutic items and services related to the surgical procedure; Administrative, record-keeping, and housekeeping items and services; Blood, blood plasma, platelets.

The Medical Assistance program pays the lesser of the usual and customary charge or a fee based upon a Division fee schedule available on the agency website http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml. The Division fee schedule was set as of 8/1/11 and is effective for dates of services provided on or after that date. The fee schedule is the same for both governmental and private providers.

29. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Reimbursement for covered professionals are outlined in Attachment 4.19-B, page 1 through 1.a.1 for the applicable provider type.

The Medical Assistance program pays the lesser of the usual and customary charge or a fee based upon a Division fee schedule available on the agency website http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml. The Division fee schedule was set as of 8/1/11 and is effective for dates of services provided on or after that date. The fee schedule is the same for both governmental and private providers.

TN #11-06

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STATE OF OREGON

Certified Psychiatric Facility Services (Non-Hospital)

This section applies to non-hospital child/adolescent residential psychiatric facilities providing inpatient psychiatric treatment services for individuals under age 21. The facilities are accredited by one of the following:

- the Joint Commission on Accreditation of Healthcare Organizations;
- the Council on Accreditation of Services for Families and Children;
- the Commission on Accreditation of Rehabilitation Facilities; or
- any other accrediting organization, with comparable standards, that is recognized by the State.

The facilities provide services under the terms of a written agreement with the Mental Health and Developmental Disability Services Division (the Division). The Division pays for such services on the basis of a prospective daily rate schedule determined by the State to represent 100% of the reasonable costs of economically and efficiently operated facilities, consistent with quality of care. Providers must submit billings that are based upon allowable costs as set forth in Office of Management and Budget Circular A-122, "Cost Principles for Non-Profit Organizations". In no case may billings exceed the prevailing charges in the locality for comparable services under comparable circumstances.

RATE SETTING

To establish maximum billing rates, the Division periodically renews a per diem rate schedule that represents 100% of the reasonable costs of economically and efficiently operated facilities providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The rates are adequate to assure reasonable access to necessary psychiatric treatment services, taking into account geographic location, type of child/adolescent served and reasonable travel time.

AUDITING

The Division will periodically review the financial records of each participating child/adolescent residential psychiatric facility, allowing reasonable notification time to the facility.

The Division will subject patient utilization of child/adolescent residential psychiatric facilities to periodic professional review to determine appropriateness. If review of a Medicaid patient's records reveals that a patient has received an inappropriate level of care, i.e., less than active treatment, the Division will not allow payment.

Enhanced Teaching Physician and Other Practitioners Fee-For-Service Reimbursement:

Effective April 1, 2005, physician services and other practitioner services provided by physicians and other practitioners affiliated with a public academic medical center that meets the following eligibility standards shall be eligible for a supplemental teaching physician and other practitioners payment for services provided to eligible recipients and paid for directly on a fee-for-service basis. Other practitioners include Clinical Psychologists and Psychiatrists, Dentists, Optometrists, Physician Assistants, Nurse Practitioners and Registered Nurses, Physical Therapists, and Occupational Therapists. Payment shall be equal to the difference between the physicians' and other practitioners' Medicare allowable for such services and Medicaid reimbursement received.

- (1) The hospital must be located within the State of Oregon (border hospitals are excluded); and
- (2) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

Payments shall be at least annually during each federal fiscal year, based on the annual difference between physicians' and other practitioners' Medicare allowable and Medicaid allowable by eligible physicians and other practitioners for the most recently completed state fiscal year. Services included are physician and other practitioners' services with RVU weights and physician injectable drugs.

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Reserved for future use

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Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this state plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

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Community First Choice State Plan Option

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services provided under the Community First Choice Option. The agency's fee schedule is effective for services provided on and after July 1, 2023. Rates are published at: <http://www.oregon.gov/dhs/spd/pages/provtools/index.aspx> and Personal Support Workers rate are published at <http://www.dhs.state.or.us/spd/tools/dd/cm/In-Home-Expenditure-Guidelines.pdf>

The following 1915(k) provider types are reimbursed in the manner described:

Assisted Living Facility- Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:

Level 1 -- All individuals qualify for Level 1 or greater.

Level 2 -- Individual requires assistance in cognition/behavior AND elimination or mobility or eating.

Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

Level 5 -- Individual is full assist in three to six activities of daily living OR full assist in cognition/behavior AND one or two other activities of daily living.

Behavioral Support Consultants- DHS developed rates for Behavioral Coaches and Behavioral Consultants based on the usual and customary charges for similar services provided within Oregon.

Community Transition Providers- Payments are based on lowest market rate as evidenced by at least three bids.

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Home Accessibility Adaptations Providers- A scope of work is created for the adaptation. From the scope of work, bids or estimates of the cost of the adaptation are received from multiple qualified providers. The provider who submits the most cost-effective bid or estimate is chosen to complete the home adaptation.

Home Delivered Meal Providers- Home Delivered Meal rates are established utilizing detailed cost reports. The Department conducts an analysis of the cost reports. A weighted average is used to determine a statewide reimbursement rate.

Homecare and Personal Support Workers- Reimbursement rates for Home Care Workers and Personal Support Workers that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. Mileage reimbursement is collectively bargained, as well.

Community Transportation Providers- Contract rates for transportation brokerages are individually negotiated with the provider. The rates are based on a cost allocation model supplied by each transportation brokerage.

APD Adult Foster Care- Medicaid reimbursement rates for APD Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two year intervals. The collective bargaining process is a public process.

Adult Foster Homes are paid a base rate with add-ons for specific medical, behavioral and ADL needs. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if:

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- (A) The individual is full assist in mobility or eating or elimination;
- (B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or
- (C) The individual's medical treatments, as selected and documented on the SPD CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

DD Children's Foster Care- A functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

DD Children's Host Home- Each individual's support needs are assessed using a functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual LOC redeterminations, annual ISP meetings, and when changes are brought to the person-centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community. The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating this service.

DD Adult Foster Care- The functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

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Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two year intervals. The collective bargaining process is a public process.

Contracted Group Care Homes for Adults- Each individual's support needs be assessed using a functional needs assessment annually, when an individual requests it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual Level of Care (LOC) redeterminations, annual PCSP meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community.

- The functional needs assessment collects information about the person's support needs . This information is used to match the individual with one of several levels of expected support need.
- A funding tier is assigned. Each funding tier corresponds to one of the functional needs assessment derived expected support levels.
- Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.

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State Operated Group Care Homes for Adults- Each individual's support needs are assessed using a functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual LOC redeterminations, annual POC meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community. The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that DHS can assure that the total funding does not exceed the cost of operating the site.

Group Care Homes for Children- Each individual's support needs are assessed using a functional needs assessment annually, when an individual request it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual Level of Care (LOC) redeterminations, annual PCSP meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend, or member of the community.

- The functional needs assessment collects information about the person's support needs. This information is used to match the individual with one of several levels of expected support need.
- A funding tier is assigned. Each funding tier corresponds to one of the support levels as determined by the functional needs assessment.
- Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.

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The rate setting budget tool incorporates OPE, allowable administration percentages, and other costs associated with operating a business. The tool incorporates information on revenue and expenses about the service site, so that DHS can assure that the resulting budget reflects ONLY the supports for the specific individual and that the total site funding does not exceed the cost of operating the site.

Residential Care Facility Regular- Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if

The individual is full assist in mobility or eating or elimination;

(B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or

(C) The individual's medical treatments, as selected and documented on the SPD CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

Residential Care Facility Contract- Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:

Supplemented Program Contract: A supplemented program contract pays a rate in excess of the published rate schedule to providers in return for additional services delivered to target populations.

Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of clients all of whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population.

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Contracted rates are approved centrally. The provider submits a proposal for a contracted rate. A committee at DHS Central Office consisting of both program staff/management and rate staff/management review the proposal and determine if the provider meets the criteria. Contracted rates are renegotiated at contract renewal, usually at 1-2 year intervals.

Specialized Living Services Provider- Contract rates for specialized living providers are individually negotiated with the provider.

Long-term Care Community Nursing Services Registered Nurses- LTCCNS Registered Nurses are paid an hourly rate based on the current Department Published Rate Schedule. Rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. The LTCCNS RN will request prior-authorization and submit claims for client services utilizing billing codes per instructions in the LTCCNS RN Service Policy and Procedure Manual.

Emergency Response Providers- Rates are established using usual and customary local market rates.

Adult Day Providers- Rates are established using usual and customary local market rates.

Supported Living (SL) Agency Providers- The SL rate is individualized and based on the agency support and level of staffing required to meet the individual's assessed support needs as determined in the service plan. The SL budget is completed on the DHS mandated budget tool using DHS established rates for direct care staff and administrative costs.

Habilitation Agency Providers- The Habilitation budget tool is individualized and based on what level of staff and agency supports are required to meet specific individual service needs. The budget tool is completed on DHS mandated formats, and uses DHS established rates for direct care staff and administrative costs.

Exceptional Rate Payments- Exceptional rate payments may be made for services provided in Adult Foster Homes, Residential Care Facilities, and In-Home Services recipients. The services provided under an exceptional rate are for direct services provided to an individual. These are exceptional payments made to providers for services, documented in the PCSP that require additional levels of skill, additional staffing or more hours to provide care on the part of the provider.

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The provider's skill level relates to the provider's ability to provide services to an individual with complex medical or behavioral needs. The provider may need to hire additional staff with additional knowledge or abilities consistent with the needs of the individual specifically to provide care to that individual. Additional staffing may be the result of an individual who needs two-person transfers or an individual with unscheduled nighttime needs that precludes the primary provider from being able to sleep for more than 4 hours in a night.

Individuals needing ventilator care may require multiple providers that have fairly extensive knowledge of the provision of ventilator care. The payments are requested at a rate above the scheduled rate for the individual's assessed need.

Rates paid to community-based facility providers are an all-inclusive rate intended to cover the individual's needs identified in the person-centered service plan. Rates do not include the costs for room and board.

Rates paid to providers of in-home services include an hourly rate and may include the taxes and benefits associated with the compensation of Home Care and Personal Support Workers. Home Care Workers, Personal Support Workers may receive exceptional or enhanced rates based on the needs of the consumer and/or special training or certification of the provider.

Exceptional payments for services provided by in-home providers are made for the provision of in-home services, documented in the PCSP, that exceed the maximum number of hours of service under rule. Based on the defined needs of the individual. All exceptional rate payments are pre-approved centrally OAR 411-027-0000 and 0050 document the services and requirements to document the need for exceptional rate payments to providers. Payment rates are the same as those for in-home services described above.

Rate variances for services received by individuals are based on a documented need in the PCSP that requires additional support or staffing that cannot be met using the standard rate ranges. Providers must demonstrate the ability to meet the individual's support needs using the additional funds provided.

Payments made for State plan services under 1915(k) authority do not duplicate payments made for similar services under 1915(c), 1915(i), 1915(j), or 1115 authorities.

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Enhanced Wage Add-on Program

The Enhanced Wage Add-on Program is designed to support Home and Community Based Services (HCBS) providers with retention of Care givers by paying a starting wage of \$15 per hour for all Caregivers, with an increase to \$15.50 per hour by the second year of the 2021-2023 biennium. HCBS providers refer to Assisted Living Facilities, Residential Care Facilities, Memory Care (Endorsed Units Only) and In-Home Agencies.

HCBS providers must submit documentation of meeting the criteria prior to being eligible for the Enhanced Wage Add-on Program.

HCBS providers who meet the criteria of the Program will receive an add-on of 10% of the Medicaid rate.

HCBS providers may be eligible between October 1, 2021 and June 30, 2023.

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Physician Services 42 CFR 447.405, 447.410, 447.415 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service adjustments.
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

For each GPCI (Work, PE, and MP) the following formula was used:

$(3 * (\text{Portland GPCI}) + 33 * (\text{Rest of State GPCI})) / 36 = \text{GPCI}$.

Then each GPCI was multiplied by the Nonfacility RVU's for that component, and the components (Work, PE, and MP) were summed. The sum of the components was then multiplied by the 2009 Medicare conversion factor, 36.0666.

Method of Payment

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code. Beginning January 1, 2014, the state will update its RVU weights from the 2013 Total RVU weights published in the Federal Register, Vol. 77, November 16, 2012 to the 2014 Total RVU weights to be published in the Federal Register, Vol. 78, December 10, 2013. (The state will not be updating the Medicare rates throughout the year)
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.
Supplemental payment is made: monthly quarterly semi-annually annually

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Primary Care Services Affected by this Payment Methodology

This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99358, 99359, 99366, 99367, 99368, 99450

The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Effective 1/1/2011-99224, 99255, 99226

Effective 1/1/13- 99485-99496

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

Medicare Physician Fee Schedule rate

State regional maximum administration fee set by the Vaccines for Children program

Rate using the CY 2009 conversion factor

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Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:

A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is:

-

Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

For children age 0 through 18:

When the sole purpose of the visit is to administer a VFC vaccine, the provider is required to bill the appropriate vaccine specific product code (90476-90748) with modifier –SL or 26 for each injection. The SL or 26 modifier indicates that it is a VFC administration of the specified vaccine. The rate of reimbursement for the administration of the vaccine was the regional maximum fee for the VFC program of \$15.19;

Adult vaccines age 19 and above:

Administration codes 90465-90474 paid based on 2008 Transitional non-facility RVU's multiplied by the Oregon conversion factor of \$27.82:

90465=\$15.58

90466= \$7.79

90467= \$9.74

90468= \$7.51

90471= \$8.07

90472=\$10.02

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Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. All rates are published at:
http://www.oregon.gov/oha/healthplan/pages/data_pubs/feeschedule/main.aspx#fee_schedule

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. All rates are published at:
http://www.oregon.gov/oha/healthplan/pages/data_pubs/feeschedule/main.aspx#fee_schedule

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Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

The Ground Emergency Medical Transportation (GEMT) program is a voluntary program that makes supplemental payments to Eligible GEMT Providers who furnish qualifying emergency ambulance services to Oregon Health Authority (OHA) Medicaid recipients.

OHA makes supplemental payments only for the uncompensated and allowable direct and indirect costs incurred while providing GEMT services to its Medicaid recipients. The supplemental payment covers the gap between the Eligible GEMT Provider's total allowable costs for providing GEMT services as reported on the Centers for Medicare and Medicaid Services (CMS) approved cost report and the amount of the base payment, mileage, and all other sources of reimbursement.

OHA makes supplemental payments only up to the amount uncompensated by all other sources of reimbursement. Total reimbursements from Medicaid including the supplemental payment must not exceed one hundred percent of actual costs.

The supplemental payments will be made at least annually on a lump-sum basis after the conclusion of each state fiscal year. These payments are not an increase to current fee-for-service (FFS) reimbursement rates.

This supplemental payment applies only to GEMT services rendered to OHA FFS Medicaid recipients by Eligible GEMT Providers on or after July 1, 2017.

A. Definitions

1. "Agency" means the Oregon Health Authority (OHA).

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2. "Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.
3. "Allowable costs" means an expenditure which meets the test of the appropriate Executive Office of the President of the United States' Office of Management and Budget Circular (OMB).
4. "Basic life support" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.
5. "Contracts with a local government" means contracts with a city, county, or local service district, including, but not limited to a rural fire protection district, and all administrative subdivisions of such city, county, or local service district, pursuant to a county plan for ambulance and emergency medical services that has been approved by the Oregon Health Authority.
6. "Direct costs" means all costs that can be identified specifically with a particular final cost objective in order to meet emergency medical transportation requirements. This includes unallocated payroll costs for the shifts of personnel, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to the delivery of covered medical transport services.
7. "Dry run" means EMT services (basic, limited-advanced, and advanced life support services) provided by an Eligible GEMT Provider to an individual who is released on the scene without transportation by ambulance to a medical facility.

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8. "Eligible GEMT Provider" means a GEMT provider that meets all of the eligibility requirements described in [Section B] below.
9. "Federal financial participation (FFP)" means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the State Plan for medical assistance. Clients under Title XIX are eligible for FFP.
10. "GEMT Services" means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by Eligible GEMT Providers before or during the act of transportation.
11. "Indirect costs" means the costs for a common or joint purpose benefitting more than one cost objective which are allocated to each objective using an agency-approved indirect rate or an allocation methodology.
12. "Limited advanced life support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services.
13. "Publicly owned or operated" means a unit of government which is a State, a city, a county, a special purpose district, or other governmental unit in the State that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

14. "Service period" means July 1 through June 30 of each Oregon state fiscal year (SFY).
15. "Shift" means a standard period of time assigned for a complete cycle of work, as set by each Eligible GEMT Provider. The number of hours in a shift may vary by GEMT provider, but will be consistent to each GEMT provider.

B. GEMT Provider Eligibility Requirements

To be eligible for supplemental payments, GEMT providers must meet all of the following requirements:

1. Be enrolled as an Oregon Health Plan Medicaid provider for the period being claimed on their annual cost report;
2. Provide ground emergency medical transport services to Medicaid recipients; and
3. Be an organization that:
 - a. Is publicly owned or operated; or
 - b. Contracts with a local government, as defined in [Section A].

C. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

2. Medicaid base payments to the Eligible GEMT Providers for providing GEMT services are derived from the ambulance FFS fee schedule established for reimbursements payable by the Medicaid program by procedure code. The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursements is the Oregon Medicaid Management Information System (MMIS). The number of paid Medicaid FFS GEMT transports is derived from and supported by the MMIS reports for services during the applicable service period.
3. The total uncompensated care costs of each Eligible GEMT Provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each Eligible GEMT Provider providing GEMT services to Oregon Medicaid beneficiaries, net of the amounts received and payable from the Oregon Medicaid program and all other sources of reimbursement for such services provided to Oregon Medicaid beneficiaries. If the Eligible GEMT Providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program. Total reimbursement from Medicaid must not exceed one hundred percent of actual cost of providing services to Oregon Medicaid beneficiaries.

D. Cost Determination Protocols

1. An Eligible GEMT Provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

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Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

2. Direct costs for providing medical transport services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.
3. Indirect costs are determined in accordance to one of the following options.
 - a. Eligible GEMT Providers that receive more than \$35 million in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the Eligible GEMT Provider does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.
 - b. Eligible GEMT Providers that receive less than \$35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, Eligible GEMT Providers may use methods originating from a CAP to identify its indirect cost. If the Eligible GEMT Provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.

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Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

- c. Eligible GEMT Providers which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
 - i. A CAP with its local government
 - ii. An indirect rate negotiated with its local government
 - iii. Direct identification through use of a cost report
 - d. If the Eligible GEMT Provider never established any of the above methodologies, it may do so, or it may elect to use the 10% *de minimis* rate to identify its indirect cost.
4. The GEMT provider-specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs of the specific provider by the total number of medical transports provided by the provider for the applicable service period.
 5. “Dry run” as defined in [Section A] is a covered service and the costs associated with a dry run should be included in the total allowable costs and counted as an allowable medical transport.
- E. Interim Supplemental Payment
1. Each Eligible GEMT Provider must compute the annual cost in accordance with the Cost Determination Protocols [Section D] and must submit the completed annual as-filed cost report, to OHA within five (5) months after the close of the State’s Fiscal Year.
 2. OHA will make annual interim supplemental payments to Eligible GEMT Providers. The interim supplemental payments for each Eligible GEMT Provider is based on the provider’s completed annual cost report in the format prescribed by OHA and approved by CMS for the applicable cost reporting year.

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Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

3. To determine the interim supplemental GEMT payment rate, OHA must use the most recently filed cost reports of all Eligible GEMT Providers to determine the average cost per transport, which will vary between the providers.

F. Cost Settlement Process

1. The payments and the number of transport data reported in the as-filed cost report will be reconciled to the OHA MMIS reports generated for the cost reporting period within **1** year of receipt of the as-filed cost report. OHA will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.
2. Each Eligible GEMT Provider will receive payments in an amount equal to the greater of the interim payment or the total CMS approved Medicaid-allowable costs for GEMT services.
3. OHA will perform a final reconciliation where it will settle the provider's annual cost report as audited within the following calendar quarter. OHA will compute the net GEMT allowable costs using audited per-medical transport cost, and the number of fee-for-service GEMT transports data from the updated MMIS reports. Actual net allowable costs will be compared to the total base and interim supplemental payment and settlement payments made, and any other source of reimbursement received by the provider for the period.

If, at the end of the final reconciliation, it is determined that the Eligible GEMT Provider has been overpaid, the provider will return the overpayment to OHA and OHA will return the overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If an underpayment is determined, then the Eligible GEMT Provider will receive an interim supplemental payment in the amount of the underpayment.

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G. Eligible GEMT Provider Reporting Requirements

1. Submit CMS approved cost reports to OHA no later than five (5) months after the close of the SFY, unless the Eligible GEMT Provider has made a written request for an extension and such request is granted by OHA.
2. Provide supporting documentation to serve as evidence supporting information on the cost report and the cost determination.

Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

3. Keep, maintain, and have readily retrievable, such records to fully disclose reimbursement amounts to which the Eligible GEMT Provider is entitled, and any other records required by CMS.
4. Comply with the allowable cost requirements provided in Part 413 of Title 42 of the Code of Federal Regulations, 2 CFR Part 200, and Medicaid non-institutional reimbursement policy.

H. Agency Responsibilities

1. OHA will submit to CMS claims based on total computable expenditures for services provided that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.
2. OHA will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law.
4. OHA will complete the audit and final reconciliation process of the interim supplemental payments for the service period within 9 months of the postmark date of the cost report and conduct on-site audits as necessary.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Dental Service- Pay for Performance Supplemental Payment Program

Effective January 1, 2019, qualifying dental providers will receive performance supplemental Medicaid payments upon providing preventive services to new Medicaid dental clients receiving Medicaid dental services for the first time.

A Qualifying dental provider means a dentist, I/T/U health clinic or Dentist working for an I/T/U health clinic, who is currently or newly enrolled as a Medicaid provider in an individual, facility, institution, corporate entity, or other organization that supplies health services or items also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of the rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.

New Medicaid dental client means any adult or child client who is enrolled in the Medicaid program and has not received dental services through these resources in the prior two years.

New and existing qualifying dental providers will be eligible for performance supplemental payments as follows:

Access tier 1: Qualifying dental providers taking a minimum of five (5) new Medicaid clients and who render at least one preventive service to those clients, dates of service between January 1, 2019 and June 30, 2020, will receive a supplemental payment of \$200 for the dental benefit/service rendered to each of the five clients for a total of \$1,000 as an enhanced payment.

Access tier 2: Qualifying dental providers taking an additional twenty (20) new Medicaid clients (for a total of 25 new clients) and who render at least one preventive service to those clients with dates of service between January 1, 2019 and June 30, 2020 will receive a supplemental payment of \$50 for the dental benefit rendered to each of the additional twenty new clients for a total of an additional \$1000.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Dental Service- Pay for Performance Supplemental Payment Program (Cont)

Dental providers qualifying for the supplemental performance payment in Access-tiers 1 and 2 will be identified through a monthly reporting process that will capture new clients by Medicaid ID with the dates of service for prevention services after January 1, 2019. Upon verification of report information, a supplemental performance payment will be authorized.

Quality tier 3: Qualifying dental provider locations meeting a set benchmark of preventive service utilization for the practice are eligible for a supplemental payment of \$1,000. Benchmarks specific to dental locations is equal to a 10 percentage point increase in rate of preventive services provided to all OHP clients at practice location.

In the event a new dental service location enrolls in the Medicaid FFS program, these locations will be subject to the State's pre-determined benchmark based on their county.

Baseline benchmark data by service location will be established at start of program (January 1, 2019) and shared with existing office locations.

The department's pre-determined number will be derived from the county's proportional expected contribution to the statewide utilization increase of existing service office locations. The new service office location's pre-determined benchmark will be the average number of additional beneficiaries among all of the existing service office locations in the county necessary to increase the statewide goal of 10 percent. Providers locations reaching Tier 3 will be assessed and issued a supplemental performance payment during the regular monthly data period process.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Telemedicine/telehealth:

The Authority reimbursement of patient to clinician telephonic and electronic services for Established patients are based upon a Relative Value Unit (RVU) weight-based rates for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes as published in the Federal Register annually with periodic updates, multiplied by the Oregon specific conversion factor.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 5/19/23 and is effective for services provided on or after that date. State-wide fee schedules are published on the agency's web at <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT)

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder (OUD) will be reimbursed using the same methodology as described for prescribed drugs as referenced on Attachment 4.19-B, section 12 for both dispensed and administered prescribed drugs.

Counseling services and behavioral health therapy payments are based on a state-wide fee schedule as referenced on Attachment 4.19-B, section 13.d.

Bundled MAT drugs and biologicals provided by Opioid Treatment Programs (OTPs) that meet the requirements for 42 CFR part 8 will be reimbursed by utilizing the state-wide physician fee schedule as outlined in Attachment 4.19-B and published on the divisions web at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

§1915(i) State plan HCBS
 State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate.

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input checked="" type="checkbox"/>	<p>HCBS Personal Care</p> <p>Reimbursement rates for Personal Care Attendants/Personal Support Workers that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Oregon Health Authority with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. Mileage reimbursement is collectively bargained, as well.</p> <p>In-home agency rates are determined through contract and are based on market rates.</p>
<input type="checkbox"/>	HCBS Adult Day Health
<input checked="" type="checkbox"/>	<p>HCBS Habilitation</p> <p>Payment methods for HCBS Residential Habilitation and Community-Based Integrated Supports use standard code sets such as CPT, HCPCS and modifiers. Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services.</p> <p>Payment for services provided in the following OHA licensed community-based residential treatment settings, will be made using the approved rate methodology as follows:</p> <ul style="list-style-type: none"> Residential treatment home/facility, OHA has developed a standardized rate based upon actuarially sound principles for personal care services tiered for different levels of client acuity needs in a range of bed size bands. The tiered rates are developed for the Oregon specific regions for annually adjusted minimum wage trended forward. The personal care service rates provided in these residential settings do not include reimbursement for room and board. The fee schedule is posted on the agency web at: https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

HCBS Habilitation (Cont)

- Adult Foster Homes-Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Oregon Health Authority with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

An individual's assessed needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need.

Payment for services provided in the following DHS-licensed/certified community-based residential settings will be made using the approved rate methodology for services provided in these settings under the 1915(k) Community First State Plan Option and as described below:

- Assisted Living Facility - Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. An Independent and Qualified Agent conducts the needs assessment using the LOCUS and LSI assessment tools for individuals enrolled in 1915(i) are the LOCUS and LSI assessments, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:
 - Level 1 - All individuals qualify for Level 1 or greater.
 - Level 2 - Individual requires assistance in cognition/behavior AND elimination or mobility or eating.
 - Level 3 - Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.
 - Level 4 - Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

<input checked="" type="checkbox"/>	<p>HCBS Habilitation (Cont)</p> <ul style="list-style-type: none">▪ Level 5 - Individual is full assist in three to six activities of daily living OR full assist in cognition/behavior AND one or two other activities of daily living.• Group Care Homes for Adults - Each individual's support needs be assessed using a functional needs assessment annually, when an individual request's it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual person-centered planning meetings, and when there are changes to the person's condition:<ul style="list-style-type: none">▪ The functional needs assessment collects information about the person's support needs. This information is used to match the individual with one of several levels of expected support need. For individuals enrolled in 1915(i), the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment.▪ A funding tier is assigned. Each funding tier corresponds to the functional needs assessment derived expected support levels.▪ Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.• State Operated Group Care Homes for Adults - Each individual's support needs are assessed using a functional needs assessment. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual eligibility redeterminations, annual person-centered service plan meetings, and when there are changes to the person's condition.
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§1915(i) HCBS State plan Services
State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

<input checked="" type="checkbox"/>	HCBS Habilitation (Cont)
	<ul style="list-style-type: none">• State Operated Group Care Homes for Adults – (Cont) The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that DHS and OHA can assure that the total funding does not exceed the cost of operating the site.• Residential Care Facility Regular - Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the APD functional needs assessment to determine the base rate and any potential add-ons. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if:<ul style="list-style-type: none">▪ (A) The individual is full assist in mobility or eating or elimination;▪ (B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or▪ (C) The individual's medical treatments, as documented in the needs assessment, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.• Residential Care Facility Contract - Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:<ul style="list-style-type: none">▪ <u>Supplemented Program Contract</u> (as referred to in 1915(k) state plan): Allows an enhanced rate for additional services in excess of the published rate schedule to providers in return for additional services delivered to target populations.

§1915(i) HCBS State plan Services
 State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

<input checked="" type="checkbox"/>	<p>HCBS Habilitation (Cont)</p> <ul style="list-style-type: none"> • Residential Care Facility Contract – (Cont) <ul style="list-style-type: none"> ▪ Residential Care Facility Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of individuals whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population. • APD Adult Foster Care - Medicaid reimbursement rates for Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process. An individual’s assessed needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need. <p>Except as otherwise noted in the plan, state-developed fee methodology rates are the same for both governmental and private providers of HCBS habilitative services. The provider types, can bill, depending on the services provided, in 15-minute units, daily or monthly frequency, accordingly to the CPT/HCPCS billing code utilized. HSD will periodically audit the providers to ensure the appropriateness of the rates. Rate reviews are conducted continuously, and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third-party administrator.</p>
<input type="checkbox"/>	<p>HCBS Respite Care</p>

§1915(i) HCBS State plan Services
 State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

For Individuals with Chronic Mental Illness, the following services:	
<input checked="" type="checkbox"/>	<p>HCBS Psychosocial Rehabilitation</p> <p>Payment methods for HCBS Psychosocial Rehabilitation use standard code sets such as CPT, HCPCS and modifiers. Existing Codes will be paired with the modifier “HW” to identify them as State Plan HCBS services. The agency uses a state-wide fee schedule that will update on 1/1/2022 and is applicable to services rendered on or after that date. The fee schedule is posted on the agency web at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of HCBS Psychosocial Rehabilitation services. The provider types, can bill, depending on the services provided, in 15-minute units, daily or monthly frequency, accordingly to the CPT/HCPCS billing code utilized.</p> <p>Psychosocial Rehabilitation (PSR): H2017 Psychosocial Rehabilitation 15-minutes; H2018 Psychosocial Rehabilitation Per-diem.</p> <p>HSD will periodically audit the providers to ensure the appropriateness of the rates. Rate reviews are conducted continuously, and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third-party administrator.</p>
<input type="checkbox"/>	<p>HCBS Clinic Services (whether or not furnished in a facility for CMI)</p>

§1915(i) HCBS State plan Services
State/Territory: Oregon

Methods and Standards for Establishing Payment Rates

For Individuals with Chronic Mental Illness, the following services:	
<input checked="" type="checkbox"/>	Other Services (specify below)
	<p><u>Home Delivered Meals</u>- Home Delivered Meal rates are established utilizing detailed cost reports. The Department conducts an analysis of the cost reports. A weighted average is used to determine a statewide reimbursement rate.</p> <p><u>Community Transportation</u>- Reimbursement rates for mileage for Personal Support Workers and Personal Care Attendants that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. Transportation rates for public transportation and other private transportation is the market rate for the service.</p> <p><u>Transition services</u> - Rates are based on market rates for all items and services.</p> <p><u>Housing Services</u>- rates for housing services providers is based on the case management rate for Independent Qualified Agents.</p> <p><u>Pest eradication services</u>- Rates are based on market rates for all items and services.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGONMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Reimbursement for language assistance services:

OHA will reimburse providers for interpreters required for limited and non-English speaking members and/or deaf/hard of hearing members, when these services are necessary and reasonable to communicate effectively with members regarding health needs. Interpreter services can only be covered in conjunction with another covered OHP service or medically necessary follow-up visit(s) to the initial covered service. To be reimbursable the language assistance service must be provided by a qualified or certified interpreter as described in Oregon Revised Statute, chapter 413, be included on the Health Care Interpreter Registry or is one of the exceptions listed in ORS 413. The registry can be searched online at <https://hciregistry.dhsoha.state.or.us>.

Providers must use the following code when billing for reimbursement for interpreters for members with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing:

- HCPCS code: T1013 (D9990 for Dental);
- Maximum units to be billed per Medicaid service/service delivery date: ONE
- Rate \$60 per unit (limit 1 unit per day)

The following are not reimbursable interpreter services:

- (A) Family members or personal friends used as interpreters, unless the family member/ friend is a Certified or Qualified Healthcare Interpreter found on the OHA Interpreter Registry;
- (B) Interpreter services when no other covered OHP service is performed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Reimbursement for language assistance services(Cont):

Provider types ineligible for separate reimbursement:

- (A) Inpatient Hospitals-- included in the inpatient hospital DRG payment method;
- (B) Federally Qualified Health Centers (FQHCs) – costs are included in the encounter rate;
- (C) Rural health clinics (RHCs) – costs are included in the encounter rate;
- (D) Indian Health Service (IHS) – costs are included in the encounter rate;
- (E) Long-term care facilities – included in the per diem rate;
- (F) Non-Emergency Medical Transportation providers – the service of transporting a patient does not include interpreter service reimbursements;
- (G) Home Health Agencies- reimbursement based on Medicare cost report.
- (H) Certified Community Behavioral Health Clinics (CCBHCs) – costs are included in the encounter rate.
- (I) Residential Treatment Facilities and Residential Treatment Homes as defined in ORS 443.400 – included in the per diem rate;
- (J) OHA Licensed Mental Health Adult Foster Homes as defined in ORS 443.705 – included in the per diem rate;
- (K) Hospice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item A of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters.
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

TN No. 91-25
Supersedes
TN No. ____

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
	Part B <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
Other Medicaid Recipients	Part A <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
	Part B <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
Dual Eligible (QMB Plus)	Part A <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
	Part B <u>SP</u>	Deductibles <u>SP</u>	Coinsurance

TN No. 91-25

Supersedes
TN No. _____

Revision: HCFA-PM-91-4 (BPD)

Approval Date 1/23/92 Effective Date 11/1/91
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Transmittal #91-25

Supplement 1 to ATTACHMENT 4.19-B

AUGUST 1991

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OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

- A. Payment for coinsurance and deductibles for Medicare non-institutional services not covered by Medicaid will be at 51% of Medicare's rate for the service.

TN No. 91-25

Supersedes

TN No. _

Approval Date 1/23/92 Effective Date 11/1/91

HCFA ID: 7982E

STATE OF OREGON

1. (Reserved for future use)

“Pen & Ink” change

TN# 95-09

Supersedes

TN# 90-06

Date Approved 5/2/96

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Comments Pen & Ink change authorized by State April 17, 1996

STATE OF OREGON

1. (Reserved for future use)

“Pen & Ink” change

TN# 95-09

Supersedes

TN# 90-06

Date Approved 5/2/96

Effective Date 9/1/95

Comments Pen & Ink change authorized by State April 17, 1996

II. The following limitations apply to residents in intermediate care facilities for the mentally retarded or persons with related conditions:

- A. The Division may make a reserved bed payment for those residents whose Plan of Care provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absence due to hospitalization. The MR/DD Specialist must be notified in writing of any resident's absence from the facility.
- B. Prior to the resident's departure for leave to exceed 14 consecutive days, the facility must submit a written request to the MR/DD Specialist for authorization of reserved bed payments. In case of emergency, notification should be made as soon as possible; but in any event not later than the working day following the resident's departure.
 - 1. Absences of less than 14 days do not require prior authorization, but the Division reserves the right to decline payment, if appropriate.
 - 2. The MR/DD Specialist must notify the Division's Chief, MR/DD Medicaid Services, of any temporary absence in excess of 30 consecutive days. Prior authorization of such absences requires the signature of both the MR/DD Specialist and the Chief, MR/DD Medicaid Services.
- C. The MR/DD Specialist shall notify the local AFS branch office in writing of any reserved bed denials. Reserved bed payments will not be made for a resident who does not return to the facility on or before expiration of any temporary or prior authorized absence unless the facility terminated the leave of absence and discharged the resident immediately upon learning the resident would not return to the facility.
- D. Reserved bed payments shall be limited to 14 days in any 30-day period, except for those absences prior authorized by the MR/DD Specialist.
- E. Failure of the facility to comply with the provisions of this rule shall relieve the Division and the Title XIX resident of all responsibility to make payment to the facility during the resident's absence. The provisions of this section are separate and apart from OAR 309-41-043.

TN # 90-6

Date Approved 9/2/90

Effective Date 10/1/90

Supersedes

TN # 86-43

- F. Residents temporarily absent overnight or longer from the facility on activities under the supervision of and/or at the expense of the facility shall be considered as remaining in the facility. This includes special trips of an educational or training nature, and recreational activities such as camping, fishing, hiking, etc.
- G. If respite care is provided in a reserved bed, Title XIX billing shall be reduced by the amount of money received for this service. The AFS-483 billing form must indicate the name of the person receiving respite care and show a credit for the amount of money received for that care.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

NURSING FACILITIES

Reimbursement for services provided by Nursing Facilities is made by means of rates determined in accordance with the following principles, methods, and standards which comply with 42 CFR Part 447, Subpart C.

I. Reimbursement Principles.

The payment methodology is based on the following:

- A. Reimbursement by the Senior and People with Disabilities Division of the Department of Human Services is based on a prospective, all-inclusive rate system which constitutes payment in full for services which are not reimbursed through another Medicaid payment source. The rates established for these long-term care services include reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Costs which are or can be reimbursed by Medicare Part B or a third party payer are not allowed;
- B. A standard, statewide flat rate which bears a fixed relationship to reported allowable costs;
- C. A complex medical needs add-on rate which bears a fixed relationship to the standard flat rate;
- D. A ventilator assisted program rate which bears a fixed relationship to the standard flat rate;
- E. A pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit;
- F. A bariatric rate which bears a fixed relationship to the standard flat rate; and
- G. Annual review and analysis of allowable costs for all participating nursing facilities. Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident care.
- H. All Nursing Facility Financial Statements are subject to desk review and analysis to determine that the provider has included its costs in accordance with Generally Accepted Accounting Principles and the provisions of the Oregon Administrative Rules.

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II. Nursing Facility Rates.

A. The Basic Rate.

1. The Division shall pay the basic rate to a provider as prospective payment in full for a Medicaid resident in a nursing facility.
2. "Basic rate" means the standard, statewide payment for all long term care services provided to a resident of a nursing facility except for services reimbursed through another Medicaid payment source.
3. The basic rate is an all-inclusive rate constituting payment in full, unless the resident qualifies for the complex medical needs add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate). The methodology for calculating the basic rate is described in Section III.

B. The Complex Medical Needs Add-on Rate.

1. If a Medicaid resident of a nursing facility qualifies for payment at the basic rate and if the client's condition or care needs are determined to meet one or more of the medication procedures, treatment procedures or rehabilitation services described in paragraph 2 of this subsection, the Division will pay the basic rate plus the complex medical add-on rate for the additional licensed nursing services needed to meet the client's increased need to a provider as prospective payment in full.
2. "Complex Medical Needs Add-on Rate" means the standard, statewide supplemental payment for a Medicaid client of a nursing facility whose care is reimbursed at the basic rate if the client needs one or more of the following medication procedures, treatment procedures or rehabilitation services for the additional licensed nursing services needed to meet the client's increased needs.

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a. Medication Procedures

- (1) Administration of medication(s) at least daily requiring skilled observation and judgment for necessity, dosage and effect for example new anticoagulants, etc. (This category does not include routine medications, any oral medications or the infrequent adjustments of current medications);
- (2) Intravenous injections/infusions, heparin locks used daily or continuously for hydration or medication;
- (3) Intramuscular medications for unstable condition used at least daily;
- (4) External infusion pumps used at least daily. This does not include external infusion pumps when the client is able to self-bolus;
- (5) Hypodermoclysis daily or continuous use;
- (6) Peritoneal dialysis, daily. This does not include clients who can do their own exchanges;

b. Treatment Procedures

- (1) Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings;
- (2) Nasopharyngeal suctioning twice a day or more. Tracheal suctioning as required for a client who is dependent on nursing staff to maintain airway;
- (3) Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more often;
- (4) Care and services for a ventilator dependent client who is dependent on nursing staff for initiation, monitoring, and

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- (5) Is limited to Stage III or IV pressure ulcers which require aggressive treatment and are expected to resolve. The Pressure Ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer;
- (6) Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily, which require aggressive treatment and are expected to resolve;
- (7) Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. Eligible for add-on until the last day the ulcer is equivalent to a Stage III. If the stasis ulcer is chronic, it is eligible for add-on only until it returns to previous chronic status.
- (8) Unstable Insulin Dependent Diabetes Mellitus (IDDM) in a client who requires sliding scale insulin; and
 - (i) Exhibits signs/symptoms of hypoglycemia and/or hyperglycemia; and
 - (ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, transfer to emergency room; and
 - (iii) Is having insulin dosage adjustments.While all three criteria do not need to be present on a daily basis, the client must be considered unstable. A Client with erratic blood sugars, without a need for further interventions, does not meet this criteria.
- (9) Professional teaching. Short term, daily teaching pursuant to discharge or self-care plan;

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- (10) Emergent medical/surgical problems requiring short term licensed nursing observation and ~~or~~ assessment. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical/surgical problem); or
 - (11) Emergent behavior problems which involve a sudden, generally unexpected change or escalation in behavior of a client that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and care planning. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical problem);
- c. Rehabilitation Services. Utilization of rehabilitation services in the frequencies specified below are used only to determine qualification for payment of the "complex Medical Needs Add-On Rate". No separate reimbursement will be made for these services outside the approved State Plan.
- (1) Physical therapy performed at least 5 days every week;
 - (2) Speech therapy performed at least 5 days every week;
 - (3) Occupational therapy performed at least 5 days every week;
 - (4) Any combination of physical therapy, occupational therapy and speech therapy performed at least 5 days every week; or
 - (5) Respiratory Therapy at least 5 days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan or a third party payer.

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3. The basic rate plus the complex medical needs add-on rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for a supplemental payment for complex medical care in addition to the basic rate. The methodology for calculating the basic rate is described in Section III.
- C. Ventilator Assisted Program Rate.
1. If a Medicaid resident of a nursing facility qualifies for payment at the ventilator assisted program rate and meets the requirements described in paragraph 2 of the subsection, the Division will pay the ventilator assisted program rate stated in Section III.B.1.c.
 2. Ventilator Assisted Program Rate means the statewide payment for all long term care services provided to a Medicaid resident of a Ventilator Assisted Program Unit who meets the requirements below, except for services reimbursed through another Title XIX payment source.
 - (a) Is chronically dependent on an invasive mechanical ventilator to sustain life;
 - (b) Requires the ongoing use of a CPAP or Bi-Pap to sustain life; or
 - (c) Is receiving necessary support and services during the transition from mechanical ventilation to a lower level of service.
 3. The Ventilator Assisted Program Rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for the services necessary to accommodate the needs of a person in a Ventilator Assisted Program. The methodology for calculating the Ventilator Assisted Program Rate is described in Section III.
- D. Pediatric Rate.
1. Notwithstanding subsections A and B, if a Medicaid resident under the age of 21 is served in a "pediatric nursing facility" or a "self-contained pediatric unit", as those terms are defined in Section III.C. The Division shall pay the pediatric rate stated in Section III.C.2. as prospective payment in full.

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2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.
3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

D. Bariatric Rate.

1. Bariatric rate means the statewide payment for all long term care services provided to a Medicaid bariatric consumer who has a physician diagnosis of obesity with BMI > 40; and meets the following criteria as defined in OAR 411-015:
 - (a) Two-person full assist with ambulation or transfers; and
 - (b) Full assist in one of the following: cognition, eating or elimination.
2. If a Medicaid resident of a nursing facility qualifies for payment at the bariatric rate and meets the requirements described in paragraph 1 of the subsection, the Division will pay the bariatric rate stated in Section III.B.1.d.
3. If a Medicaid individual meets the criteria listed in paragraph 1 of this subsection, and the Division has authorized the bariatric rate, the nursing facility must provide one (1) additional Certified Nursing Assistant, above the licensing staffing standard, for every five (5) individuals receiving the bariatric rate.
4. The Bariatric Rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for the services necessary to accommodate the needs of a bariatric person. The methodology for calculating the Bariatric Rate is described in Section III.

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E. Other Payments.

1. Medicare. The Division shall pay the coinsurance rate established under Medicare, Part A, Hospital Care for care rendered to an eligible client from the 21st through the 100th day of care in a Medicare certified nursing facility.
2. Swing Bed Eligibility. To be eligible to receive a Medicaid payment under this rule, a hospital must:
 - (a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

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- (b) Have a Medicare provider agreement for acute care; and
- (c) Have a current signed provider agreement with the Seniors and People with Disabilities Division to receive Medicaid payment for swing-bed services.

(1) NUMBER OF BEDS:

- (a) A Critical Access Hospital (CAH) that is not located within a 30 mile geographic radius of a licensed nursing facility as of March 13, 2007 may provide swing bed services to up to 20 Medicaid residents at one time. The CAH must maintain at least five beds or twice the average acute care daily census, whichever is greater, for exclusive acute care use;
- (b) Other hospitals providing swing bed services under this rule may not receive provide such services to more than five Medicaid residents at one time. In addition, the residents must have a documented need for and receive services that meet the complex medical add-on requirements outlined in OAR 411-070 as of July 1, 2009, This OAR contains relevant details of the State's NF reimbursement methodology and as such is adhered to by the State;
- (c) If circumstances change so that a CAH receiving payment for Medicaid services pursuant to section (2)(b) of this rule meets the criteria set out in section (2)(a) of this rule after March 13, 2007, the CAH may petition the Division for authorization to receive such payment pursuant to section (2)(a) of this rule. The Division will evaluate all available long-term care resources within a 30 mile geographic radius of the CAH and the amount of unmet long-term care need in the same area and determine if the CAH will be authorized to receive payment pursuant to section (2)(a) of this rule.

(2) PAYMENT:

- (a) Daily Rate. Medicaid payment for swing-beds will be equal to the rate paid to Oregon's Medicaid certified nursing facilities.

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(b) Medicare Co-payment. Medicaid payment for Medicare co-insurance for Division clients will be made at a rate which is the difference, if any, between the Medicare partial payment and the facility Medicaid rate.

(3) ADMISSION OF CLIENTS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager must determine there is no nursing facility bed available to the client within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" means a bed in a nursing facility that is available to the client at the time the placement decision is made.

3. Out-of-State Rate. When an Oregon Medicaid resident is cared for temporarily in a nursing facility in a state contiguous to Oregon while an appropriate in-state care setting is being located. In order to approve a temporary out-of-state rate, the Division must be furnished a written statement from the resident's physician that specifies an anticipated date of discharge or length of stay. Once approved, the Division shall pay the lesser of:
 - a. The Medicaid rate for the resident's level of care established by the state in which the nursing facility is located; or
 - b. The rate for which the resident would qualify in Oregon which is either the Basic Rate with a possible Complex Medical Needs Add-on payment, Ventilator Assisted Program rate, an Extreme Outlier Client Add-on payment, or the pediatric rate.

4. Outlier Client Add-On
 - a. The Division may make an outlier client add-on payment when a client has a combination of extraordinary medical, behavioral and/or social needs and no satisfactory placement can be made within the established payment categories.

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- b. The add-on will be specific to the client's care needs, based on an outlier care plan approved by the Division at the beginning of outlier care and at six month intervals thereafter, and the facility-specific direct care costs related to the client's outlier care plan.
- c. The outlier add-on will be calculated using the latest audited facility-specific unit price of the direct care component(s) whose costs are increased due to the outlier care plan.

5. Nurse Aide Training and Competency Evaluation.

The administrative expenses incurred by nursing facilities for nurse aide training and competency evaluation will be reported on a quarterly basis, and the facility will be reimbursed the eligible portion of these costs. Payments made under this provision will be on a pass-through basis outside the approved reimbursement system.

6. Trustee.

When a trustee is appointed temporarily by the court to manage a facility for protection of the health and welfare of residents, costs related to the operation of the facility which are not covered by the facility's revenue sources, including regular Medicaid rates and the State's trust fund, will be reimbursed as administrative costs under Section 6.2 of the approved State Plan.

7. Certified Nursing Assistant (CNA) Staffing Standard.

- a. The Division shall add to the basic rate and the pediatric rate a Certified Nursing Assistant staffing standard payment to work toward implementation of a new minimum CNA staffing standard of 2.46 hours per resident day (HPRD).

- (1) Raise HPRD to 2.07 on March 1, 2008
- (2) Raise HPRD to 2.31 on April 1, 2009
- (3) Raise HPRD to 2.46 on July 1, 2009

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- b. The Division shall collect quarterly staffing updates from nursing facilities and monitor staffing compliance.
- III. Financial Reporting, Facility Auditing, and the Calculation of the Standard Statewide Basic Rate, Complex Medical Needs Add-on Rate, Bariatric Rate and Ventilator Assisted Program Rate.
- A. Financial Reporting and Facility Auditing.
 1. Effective July 1, 1997, each facility files annually and for the period ending June 30 a Nursing Facility Financial Statement (Statement) reporting actual costs incurred during the facility's most recent fiscal reporting period. The Statement can be filed for a reporting period other than one year only when necessitated by a change of ownership or when directed by the Division.
 2. Each Statement is subject to desk audit within six months after it has been properly completed and filed with the Division. The Division may conduct a field audit which, if performed, will normally be completed within one year of being properly completed and filed with the Division.
 - B. Calculation of the Standard Statewide Basic Rate, Complex Medical Needs Add-on Rate, Bariatric Rate and Ventilator Assisted Program Rate.
 1. Basic Rate, Complex Medical Needs Add-on Rate, Bariatric Rate and Ventilator Assisted Program Rate.
 - a. Basic Rate. The rate is determined annually. The Basic Rate is based on the Statements received by the Division by October 31 for the fiscal reporting period ending on June 30 of the previous year. Statements for pediatric nursing facilities and ventilator assisted Program are not used to determine the Basic Rate. The Division desk reviews or field audits these Statements and determines for each nursing facility, its allowable costs less the costs of its self-contained pediatric unit and Ventilator Assisted Program unit, if any.

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For each facility, its allowable costs, less the costs of its self-contained pediatric unit or ventilator assisted Program (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the following fiscal year, by projected changes in the DRI* Index.

For each facility, its Allowable Costs Per Medicaid Day is determined using the allowable costs as inflated and resident days excluding days in a self-contained pediatric unit or ventilator assisted program unit as reported in the Statement.

- b. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Basic Rate.
 - c. Ventilator Assisted Program rate is 235% of the basic rate.
- 2. For the period beginning July 1, 2007 through June 30, 2016, the Rate is set at the 63rd percentile of allowable costs (both direct and indirect).
 - 3. Nursing facility bed capacity in Oregon shall be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veteran's Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012, or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013. An official bed count measurement shall be determined and issued by the Department prior to July 1, 2016 and each quarter thereafter if the goal of reducing the nursing facility bed capacity in Oregon by 1,500 beds is not achieved.
 - a. (a) For the period beginning July 1, 2013 and ending June 30, 2016, the Department shall reimburse costs as set forth in section (1) of this rule at the 63rd percentile.
 - b. For each three-month period beginning on or after July 1, 2016 and ending June 30, 2018, in which the reduction in bed capacity in licensed facilities is less than the goal described in this section, the Department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:
 - (A) 63rd percentile for a reduction of 1,500 or more beds.

* DRI compiled from *the IHA Economics, Healthcare Cost Review Report*, Table 6.7 titled "CMS Nursing Home without Capital Market Basket"

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(B) 62nd percentile for a reduction of 1,350 or more beds but less than 1,500 beds.

(C) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(D) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(E) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(F) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(G) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(H) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(I) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(J) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(K) 53rd percentile for a reduction of 1 to 149 beds.

4. For the period beginning July 1, 2018 through June 30, 2026, the rate is set at the 62nd percentile of allowable costs (both direct and indirect).

C. Quality and Efficiency Incentive Program.

The Quality and Efficiency Incentive Program is designed to reimburse quality nursing facilities that voluntarily reduce bed capacity. This design increases statewide occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs. As a result of the increased occupancy rates, nursing facilities that participate are likely to increase staffing levels and consolidate resources to improve the quality of care.

Only nursing facilities that meet strict quality criteria are eligible. A quality/qualifying nursing facility must have evidence of compliance with nursing facility regulations such that the health, safety or welfare of residents is or was not jeopardized. A quality nursing facility is determined eligible by multiple components including being a licensed facility by the Department, being in substantial compliance with annual licensing and recertification surveys and having no substantiated facility abuse within the preceding six months.

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The Department may provide additional compensation to nursing facilities who qualify for the legislatively approved Quality and Efficiency Incentive Program. Such compensation may not exceed \$9.75 per Medicaid resident day and may not exceed four years from the facility's date of eligibility. Eligibility to participate in this Program sunsets on June 30, 2016.

D. Pediatric Nursing Facilities.

1. Pediatric nursing facility means a licensed nursing facility, 50% of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.
2. Pediatric nursing facilities will be paid a per diem rate which rate will:
 - a. Be prospective;
 - b. Not be subject to settlement; and
 - c. The per diem rate will be calculated as follows:

The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days.

Once the weighted average cost is determined, the rebase relationship percentage (93%), is applied to set the new rate. Before computing the weighted average cost, the facility-specific total costs are inflated by a change in the DRI Index to bring the cost to the rebase year.

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3. For the services rendered between October 1, 2013 and June 30, 2020, the Department shall set the relationship percentage to 93% and rebase annually.
 4. Pediatric nursing facilities must comply with all requirements relating to timely submission of Nursing Facility Financial Statements.
- E. Licensed Nursing Facility With a Self-Contained Pediatric Unit.
1. A nursing facility with a self-contained pediatric unit means a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility.
 2. Nursing facilities with a self-contained pediatric unit will be paid in accordance with subsection C.2. of this section for pediatric residents cared for in the pediatric unit.
 3. Nursing facilities with a self-contained pediatric unit must comply with all requirements related to timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.
- F. Enhanced Wage Add-on Program

The Enhanced Wage Add-on Program is designed to support nursing facilities with retention of Certified Nursing Assistants (CNAs) by paying a starting wage of \$17 per hour for all CNAs, with an increase to \$17.50 per hour by the second year of the 2021-2023 biennium.

A nursing facility must submit documentation of meeting the criteria prior to being eligible for the Enhanced Wage Add-on Program. Nursing facilities who meet the criteria of the Program will receive an add-on of 4% of the Medicaid rate. A nursing facility may be eligible between October 1, 2021 and June 30, 2023.

IV. Public Process

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.

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Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) of this state plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

TN No. 11-16

Approval Date: 6/18/12

Effective Date: 10/1/2011

Supersedes TN No.

CMS ID: 7982E

INTERMEDIATE CARE FACILITIES
FOR
MENTALLY RETARDED
AND
OTHER DEVELOPMENTALLY DISABLED PERSONS (ICFs/MR)

Reimbursement for services provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) for Medicaid recipients is made by the Mental Health and Developmental Disability Services Division (the Division). The Division determines rates in accordance with the following principles, methods, and standards which comply with 42 CFR 447.250 through 447.256.

I. Reimbursement Principles

The payment methodology for ICFs/MR is based on the following:

- A. Development of model budgets which represent 100% of the reasonable costs of an economically and efficiently operated facility;
- B. Annual review and analysis of allowable costs;
- C. The use of interim rates (per diem) and retroactive year-end cost settlements, capped by a maximum allowable cost for each facility based on the type of facility and resident classification; and
- D. The lower of allowable costs or maximum costs.

II. Classification of ICF/MR Facilities

Three classes of ICFs/MR have been established based on classification of residents, size of the facility, and staffing requirements.

- A. "Small Residential Training Facility" (SRTF) means a Title XIX certified facility having fifteen or less beds and providing active treatment.
- B. "Large Residential Training Facility" (LRTF) means a Title XIX certified facility having from 16 to 199 beds that provides active treatment. The LRTF model budget may be applicable to a SRTF which is constructed and programmed to serve residents who are not capable of self-preservation in emergency situations.

- C. "Full Service Residential Training Facility" (FSRTF) means a facility having 200 or more certified ICF/MR beds providing the full range of active medical and day treatment services required in state and federal rules and regulations. The facility may be less than 200 beds if it meets all of the following criteria:
1. It is a certified ICF/MR and is licensed as a nursing home for the mentally retarded;
 2. It serves a high percentage of clients who are non-ambulatory, medically fragile or in some other way seriously involved;
 3. Its location is such that professionals with the knowledge of medical and dental needs of people with severe mental and physical handicaps are not generally available and must be hired as permanent staff;
 4. It serves any and all clients referred by the Division.

III. Classification of Residents

The classification of each resident in an ICF/MR is determined by use of the Division's Resident Classification Instrument.

- A. "Class A" includes any of the following:
1. Children under six years of age;
 2. Severely and profoundly retarded residents;
 3. Severely physically handicapped residents; and/or
 4. Residents who are aggressive, assaultive or security risks, or manifest severely hyperactive or psychotic-like behavior.
- B. "Class B" includes moderately mentally retarded residents requiring habilitative training.
- C. "Class C" includes residents in vocational training programs or sheltered employment. These training programs or work situations must be an integral part of the resident's active treatment program.

IV. Rate Setting - SRTFs and LRTFs

- A. For each SRTF and LRTF, the Division develops an interim rate based upon the actual licensed capacity and staffing ratios

required under the administrative rules to serve the anticipated mix of class A, B, and C residents. See pages 7 through 10 of this portion of the State plan for examples of the model interim rate worksheets. Each interim rate is calculated as the lesser of the facility's model budget rate (1) or projected net per them cost (2).

1. The model budget represents 100% of reasonable per them costs of efficiently and economically operated facilities of that size.
 - a. The model budget consists of two major cost categories: Base Costs and Labor Costs.
 - i. Base Costs (e.g., rent, utilities, administration, general overhead) are based on amounts determined by the State to be reasonable in similar sizes and types of residential facilities. The model budget rate consists of a standard per diem rate per resident for each class of facility.
 - ii. Labor Costs (e.g., for direct care, active treatment, and support staff) are broken into various components. The model budget cost-for each component is developed based on requirements in federal regulations, State regulations, the State's experience in State-operated ICFs/MR, and costs determined to be reasonable in similar facilities. Each component within the labor category has a model budget rate developed.
 - b. The facility's model budget rate is adjusted by the most recently available resident occupancy information, but not lower than 95% of the facility's licensed bed capacity.
 - i. The model budget rate at 100% occupancy is multiplied by the number of resident days at 100% occupancy to yield the ceiling amount in dollars.
 - ii. The ceiling amount is divided by the greater of:

The number of resident days projected for the facility for the upcoming fiscal period; or

95% of the total possible resident days available for a facility of that licensed capacity for the fiscal period.
 - c. Model budgets for SRTFs and LRTFs are reviewed annually and adjustments are made based on inflation, economic

trends or other evidence supporting rate changes, such as directives from the legislature or changes in program design.

- d. Model budgets will be rebased as a result of desk or field audits of the providers' cost statements.
2. The projected net per diem cost is usually derived from the facility's latest ICF/MR Cost Statement, revised to include any adjustments applied to the per them reimbursement rate schedule for subsequent periods. Adjustments have historically fallen into four categories:
 - a. Corrections to depreciation;
 - b. Modifications of indirect cost allocations;
 - c. Unallowable costs; or
 - d. Offsets of expenses against income and donations as described in the administrative rules.

However, if requested by the facility and agreed to by the Division, the facility may substitute actual allowable costs gathered from at least three months of data more recent than the latest ICF/MR Cost Statement, revised to include any adjustments applied to the per them reimbursement rate schedule for subsequent periods.

- a. The Division will consider recent data which is the equivalent of an interim cost report by the facility.
 - b. The Division will compare actual allowable costs derived from the recent data with the model budget rate and will assign a new interim rate based upon the lesser of the two.
3. The facility or the Division may request a per diem rate adjustment if a significant change in allowable costs can be substantiated.
 4. The Division pays an interim rate to each SRTF and LRTF through the end of each fiscal year. The actual (final) payment, called the year-end settlement, is discussed in part B of this section.

In the year-end settlement, the Division takes into account the interim rate payments already made and compares those payments with the settlement rate.

- B. For each SRTF and LRTF, the Division establishes a year-end settlement rate on a retrospective basis for the period covered by the respective cost statements and issues an official notice to each facility indicating the exact amount of the retroactive settlement. The settlement rate is calculated as the lower of the ceiling rate (1) or the actual net per them cost (2):
1. Ceiling rate: The facility's model budget rate will be revised, using the worksheets shown at pages 8 through 10 of this portion of the State plan, to reflect the actual number and classification of residents for the period. The product of the resulting revised rate at 100% occupancy and the number of resident days at 100% occupancy shall be the ceiling amount in dollars. The quotient of the ceiling amount and actual resident days in the period will be the ceiling rate subject to the following modifications:
 - a. If the facility is occupied at 95% or more of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and actual resident days in the period shall be the ceiling rate.
 - b. If the facility is occupied at less than 95% of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and product of 95% of the licensed bed capacity and the number of calendar days in the fiscal period shall be the ceiling rate.
 2. Actual net per diem cost The quotient of actual allowable costs, as adjusted in accordance with this plan, and actual resident days for the period, shall be the actual net per diem cost.
 3. The methodology for calculating the year-end settlement rate and amount for SRTFs and LRTFs is shown on pages 11 and 12 of this portion of the State plan.

V. Rate Setting - FSRTFs

- A. For each FSRTF, the Division develops an interim rate based on the facility's projected costs. The facility or the Division may request a rate adjustment if the basis for the prospective rate has changed and a significant change in projected costs can be substantiated.
- B. For each FSRTF, the Division develops a year-end settlement rate based upon actual costs.

VI. Costs and Services Billed

- A. Reimbursement by the Division is based on an all-inclusive rate, which constitutes payment in full for ICF/MR services. The rate established for an ICF/MR includes reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Payment for costs outside of the all inclusive rate may be authorized in specific circumstances according to criteria established in Oregon Administrative Rules. These include: the circumstance of an individual admitted to or residing in a privately operated ICF/MR who needs diversion or crisis services in order to avoid admission to a state-operated ICF/MR; the circumstance of an individual not admitted to, but residing in, a privately operated ICF/MR who is occupying a vacant or reserved bed and needs diversion or crisis services; and the circumstance of costs incurred which are related to the approved plan for diversion or crisis services.
- B. Billings to the Division shall in no case exceed the customary charges to private clients for any like item or service charged by the facility.
- C. The Division may make a reserved bed payment for those residents whose Individual Program Plan provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absences due to hospitalization or convalescence in a nursing facility. Reserved bed payments shall be limited to 14 days in any 30 day period unless prior authorized by the Division. Reimbursement will only be made to providers who accept Title XIX payment as payment in full.

VII. Cost Statements Audited

The Division shall audit each ICF/MR cost statement within six (6) months after it has been properly completed and filed with the Division. The audit will be performed either by desk review or field visit.

VIII. Provider Appeals

A letter will be sent notifying the provider of the interim per diem rate and/or the year-end settlement rate. Providers shall notify the Division in writing within 15 days of receipt of the letter, if the provider wishes to appeal the rate. Letters of approval must be postmarked within the 15 day limit.

EXAMPLE ONLY

Calculation of Interim Rate
July 1, 1991

Cost From Fiscal Year 1989-90 Audit Report	\$96.69 (1)
July 1, 1990 Inflation Factor	1.04
	100.56
July 1, 1991 Inflation Factor	1.044
Projected Net Per Diem Cost	<u>\$104.98</u>
Adjusted Model Budget Rate	<u>\$ 99.50</u>
Lower Amount is New Interim Rate	<u>\$ 99.50</u>

(1) Cost statement and desk review for FY 1990-91 not available at time of interim rate calculation.

INTERIM RATE
FOR JULY 1, 19

EXAMPLE ONLY

<u>Category</u>	<u>Original Model Budget</u>	<u>Adjustments</u>	<u>Adjusted Model Budget</u>
I Base Costs	\$0.00	\$0.00	\$0.00
II Administration			
A. Administrator	0.00		0.00
B. Assistant Administrator	0.00		0.00
C. Other Administration	0.00		0.00
Sub-Total	0.00	0.00	0.00
III Active Treatment			
A. Psychology	0.00		0.00
B. Social Work	0.00		0.00
C. Speech Therapy	0.00		0.00
D. Physical Therapy	0.00	0.00 3.	0.00
E. Occupational Therapy	0.00		0.00
F. Recreational Therapy	0.00		0.00
Sub-Total	0.00	0.00	0.00
IV Direct Care Staffing	0		0
A. Direct Care Staff	0.00	0.00 4.	0.00
B. Supervisory Staff	0.00	0.00 5.	0.00
Sub-Total	0.00	0.00	0.00
V Other Staff			
A. Skill Trainer/QMRP	0.00		0.00
B. Nursing	0.00		0.00
C. Pharmacist	0.00		0.00
D. Dentist	0.00		0.00
E. Dietitian	0.00		0.00
F. Food Service	0.00		0.00
G. Laundry	0.00		0.00
H. Housekeeping	0.00		0.00
I. Maintenance	0.00		0.00
J. In-Service Training	0.00		0.00
K. Receiving/Warehousing	0.00		0.00
Sub-Total	0.00	0.00	0.00
VI Medical Services	0.00	0.00	0.00
VII Day Programs	0.00	0.00	0.00
TOTAL	<u>\$0.00</u>	<u>\$0.00</u>	<u>\$0.00</u>

TN# 91-27
Supersedes TN# ---

Date Approved: 8/24/92
Effective Date: 10/1/91

INTERIM RATE
 FOR JULY 1,

EXAMPLE ONLY

1. Period	Days in <u>Period</u>	Licensed X	<u>Beds</u>	Capacity =	<u>Days</u>
7-1-90 thru 6-30-91	365		0		0
2. Residents by Classification (By Cottage)	Resident <u>Days</u>	/	Days in <u>Period</u>	=	Average Residents by <u>Classification</u>
A.	0		365		0.00
B.	0		365		0.00
C.			365		0.00
Total	0		365		0.00
3. Physical Therapy <u>Classification</u>	Hours Per Day per <u>Resident</u>	X	Average Residents <u>Per Day</u>	=	Resident Hours <u>Per Day</u>
A.	0.11		0.00		0.00
B.	0.04		0.00		0.00
C.	0.01		0.00		0.00
Total	0.16		0.00		0.00
Hourly Rate					14.04
Daily Rate (Total * Hourly Rate)					0.00
Average Residents per Day					0
Per Resident Day (Daily Rate*Average Residents)					
Per Resident Day Adjustment					1.16
Total per Resident Day					

INTERIM RATE
 FOR JULY 1, 19

EXAMPLE ONLY

4. Direct Care Staff

<u>Classification</u>	<u>Average</u> <u>Res. Days</u>	<u>/=</u>	<u>Shift</u>	<u>/=</u>	<u>Shift</u>	<u>/=</u>	<u>Shift</u>	<u>Total</u>
A.	0	8	0.000	8	0.000	16	0.000	
B.	0	16	0.000	8	0.000	16	0.000	
C.	0	32	0.000	16	0.000	32	0.000	
Total	0		0.000	0.000		0.000		
Rounded Total			0	0		0 =	0	
Posting Factor						X	1.63	
Total Staff								0.00
Rounded								1

0 Staff X 40 Hrs X 52 Wks / 365 Days / 84 Avg Res Per Day

X \$6.26 Hourly Rate X 1.2395 OPE = 0.00 Rate Per Resident Day.

5. Direct Care Supervisory Staff

0 Direct Care Staff / 7 = 0.00 Supervisors Rounded 0

0 Staff X 40 Hrs X 52 Wks 365 Days / 84.00 Avg Res Per Day

X \$6.16 Hourly Rate X 1.2395 OPE = 0.00 Rate Per Resident Day.

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EXAMPLE ONLY

SETTLEMENT COMPUTATION
For the Period 7-1-90 through 6-30-91

7/1/90
Through
6/30/91

Model Budget @ 100% Capacity	<u>\$95.32</u>
Capacity Days	<u>3,650</u>
Ceiling Dollars	<u>\$347,918.00</u>
Actual Resident Days	<u>3,554</u>
Ceiling Rate	<u>\$97.89</u>
Total Expenditures Per Cost Statement	<u>\$341,072.00</u>
Less: Adjustments	<u>.00</u>
Net Allowable ICF/MR Expenditures	<u>\$341,072.00</u>
Actual Resident Days	<u>3,554</u>
Actual Net Per Diem Cost	<u>\$95.97</u>
Settlement Rate (Lesser of Ceiling or Actual Net Per Diem Cost)	<u>\$95.97</u>

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Supersedes TN# ----

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EXAMPLE ONLY

COMPUTATION OF SETTLEMENT AMOUNT
 For the Period 7-1-90 through 6-30-91

The following computation for the period 7-1-90 through 6-30-91 discloses that:

- 1. The ICF/MR owes the Mental Health Division
- or
- 2. The Mental Health Division owes the ICF/MR \$1,916.40

ICF/MR FACILITY VENDOR #

Mo./Yr. Service Rate	Settlement Rate	Interim Rate	Settlement rate minus Interim Rate	Days	Resident Amount
7/90	\$95.97	\$96.59	(1) (\$.62)	310	(\$192.20)
8/90	95.97	95.32	.65	310	201.50
9/90	95.97	95.32	.65	270	175.50
10/90	95.97	95.32	.65	279	181.35
11/90	95.97	95.32	.65	270	175.50
12/90	95.97	95.32	.65	305	198.25
1/91	95.97	95.32	.65	310	201.50
2/91	95.97	95.32	.65	280	182.00
3/91	95.97	95.32	.65	310	201.50
4/91	95.97	95.32	.65	300	195.00
5/91	95.97	95.32	.65	310	201.50
6/91	95.97	95.32	.65	300	195.00

Total \$1,916.40

Facility _____

(1) This interim rate was paid prior to the rate revision in the letter dated 7-30-90.

Instructions for Preparation of the Newly Revised AFS ICF/MR Cost Statement
INTRODUCTION

The following instructions, based on the rules in the ICF/MR provider guide, will help clarify and give direction in completing the ICF/MR Cost Statement. Additional explanation to specific questions may be obtained by contacting Adult and Family Services Division. FSRTFs may disregard these instructions and use the Medicare Form 2552 portion of the ICF/MR Cost Statement and chart of accounts.

FILING OF ICF/MR COST STATEMENT

Generally, cost statements are filed on an annual basis, and are due within 90 days of the facility's REPORTING period end. Improperly completed or incomplete cost statements will be returned for proper completion, to be returned to AFS within 30 days. See Rule 461-17-920 of the ICF/MR provider guide for further explanation.

MIXED LEVEL-OF-CARE FACILITIES

If a facility provides either a skilled or semi-skilled level of care in addition to the ICF/MR level of care, the Nursing Home Cost Statement shall be completed first, so that only those dollar amounts related to the ICF/MR level of care are entered on the ICF/MR Cost Statement.

If a legal entity operating an ICF/MR program also operates programs or businesses not reimbursable under Title XVIII or Title XIX, at its discretion, the facility may decide to separate the non-ICF/MR costs before the cost statement is done, or in the adjustment column of the cost statement.

Page 1

The first page of the cost statement is used to identify the facility, list the facility's public billing rates, provide space for signature by the responsible parties, and provide space for other related information.

SIGNATURES

Both the preparer, if not an employee of the provider, and the owner or individual who normally signs the Federal Income Tax Return or other report shall sign the ICF/MR Cost Statement.

Page 2

The second page is used to identify the owners and officers, their ownership interest in the facility, services they performed for the facility, and other related information.

Page 3

The third page is used to identify other businesses with which the owners are involved, the facility administrator, and other related information.

ADMINISTRATOR SUMMARY

Include all of the designated administrators for the cost statement period and their dates of service as administrator of the facility. Also, list the current administrator.

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Page 4

The fourth page provides space for additional explanation of any item on the cost statement, and space for information on the facility and equipment.

Page 5

Page 5 is the beginning of the financial section of the cost statement.

FINANCIAL SECTION

The financial section of the cost statement has been designed so that a provider can determine his net allowable costs, and determine by cost finding his per diem cost for the ICF/MR program.

REVENUE SCHEDULE

The provider shall include all of his revenue by appropriate account as described in the chart of accounts. Except for those facilities providing a skilled or semi-skilled level of care, the first column shall include all revenue of the facility and shall be reconcilable to the facility's Income Statement or Profit and Loss Statement, and to the appropriate IRS Reports. For those facilities providing a skilled or semi-skilled level of care, see "Mixed Level-of-Care Facilities" above.

Any difference between net income per ICF/MR Cost Statement and net income per IRS report shall be reconciled on Schedule A.

The second column shall include revenues allocable from a home office net of adjustments and reclassifications.

The third column is designed so the provider can make adjustments and reclassifications to the gross revenue shown in the first column. These adjustments and reclassifications shall be made according to the provisions of the ICF/MR provider guide before the cost statement is submitted.

The first three columns total to the fourth column.

Page 6

Page six is the beginning of the base cost schedule.

BASE AND LABOR COST SCHEDULES

The provider shall include all of his expenses by appropriate account as described in the chart of accounts.

Except for those facilities providing a skilled or semi-skilled level of care, the first column shall include all expenses of the facility, and shall be reconcilable to the facility's Income Statement or Profit and Loss Statement, and to the appropriate IRS reports. For those facilities providing a skilled or semi-skilled level of care, see "Mixed Level-of-Care Facilities" above.

The second column shall include expenses allocable from a home office. This column shall be reconcilable to the home office financial statements and records. The amounts allocated shall be net of reclassifications and adjustments per provisions of this guide. See Rule 461-17-890 of the ICF/MR provider guide.

The third column is designed so the provider can make adjustments and reclassifications to the gross facility expenses in the first column per provisions of the ICF/MR provider guide. These adjustments and reclassifications shall be made before the ICF/MR Cost Statement is submitted to the Division.

If an adjustment is for a revenue producing activity relating to a non-allowable cost, the revenue shall be offset against the appropriate expense if the revenue is less than two per cent of the total provider expense. If the revenue is greater than two percent of the total provider expense, costs must be allocated to this area as described in the discussion for Cost Area Allocations.

The fourth column shall include only the net allowable costs attributable to the provider per the provisions of this guide. The first three columns total to the fourth column.

Page 7

Page seven is the last page of the base cost schedule.

Page 8

Page eight is the beginning of the labor cost schedule. See the instructions for base and labor costs above.

Page 9

Page nine is the last page of the labor cost schedule.

Page 10

Page ten shows in total the payroll taxes which are to be allocated to the various labor cost categories, and provides a form for the return on owner's equity calculation.

SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

The allowable Total Employee Benefits and Taxes (Acct. #3200), is to be allocated to the appropriate payroll and employee benefits account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll.

RETURN ON EQUITY

The return on owner's equity is calculated on page 10 of the cost statement. The rate of return is identified in Rule 461-17-860 of the IFC/MR provider guide. This same rule defines allowable equity to be included in the per diem rate. Non-profit corporations should not make this calculation since they are not allowed a return on equity.

Page 11

Page 11 is the first page of the balance sheet, and is used to identify the facility's assets.

The balance sheet must be completed as it is presented in the ICF/MR Cost Statement. Substituting another balance sheet will not suffice.

Page 12

Page 12 is the last page of the balance sheet, and is used to show the facility's liabilities and capital.

Page 13

COST AREA ALLOCATIONS SCHEDULE FOR FACILITIES WITH OTHER REVENUE PRODUCING PROGRAMS

This schedule is designed to develop the ratios to be used in allocating costs to different levels of care. If a facility provides either a skilled or semiskilled level of care in addition to the ICF/MR level of care, or operates programs or businesses not reimbursable under Title XVIII or Title XIX, see "Mixed Level of Care Facilities" above. If there is no revenue producing activity related to non-allowable cost⁵ which generates revenue in excess of 2% of the total gross expenses, this schedule need not be completed.

If an allocation method other than that specified in the schedule is Used, an explanation of the method and reason for its use must be provided on page 4 of the cost statement. A supplement to the schedule may be needed if there is insufficient space to adequately show a different allocation. The use of a different allocation method is to be used only if it is more reasonable and accurate than the prescribed method, and is subject to approval by the Division.

Each level-of-care column should contain the resident days or square related to that level-of-care by cost area as designated on the schedule. If the designation is for resident days, resident days by licensed bed in the designated ICF/MR area should be used. If the designation is for square footage of common areas, including dining, administrative offices, etc. should not be included in the square footage totals where they are used, in the same proportionate ratio by all levels of care.

The allocation base column is the total of the level-of-care columns for each cost area.

The net cost area expense column shows the dollar amount of net allowable expenses for each cost area.

The multipliers shown in the last column are used to develop the dollar amounts for the Allocated Costs schedule. Each multiplier is computed by dividing the net cost area expense by the allocation base for that cost area. If costs can be directly related to a level of care, such as might be the case for certain salaries, a multiplier should not be developed since the costs can be entered directly on the Allocated Costs schedule.

Page 14

ALLOCATED COSTS SCHEDULE

This schedule is designed to show allowable costs for the ICF/MR program by cost area, and to calculate the ICF/MR cost per day.

If no allocation via the Cost Area Allocations schedule is required, the dollar amount for each cost area will be the total net allowable expense from the base and labor cost schedules. If the allocations schedule was used, the dollar amount for each cost area is the product of the multiplier for that cost area and the level-of-care sub-total from page 13.

The grand total of the ICF/MR cost areas divided by resident days by licensed bed in the designated ICF/MR service area determines the ICF/MR cost per day.

Page 15

Page 15 provides space for explanation of the miscellaneous accounts and other accounts as needed, and space for reconciliation calculations.

Page 16

RESIDENT CLASSIFICATION REPORT

If the resident day count by level of care is the same as the resident day count by licensed bed, this should be indicated on the second schedule of this report instead of unnecessarily repeating the day count.

Page 17

BED CAPACITY SCHEDULE

The "change" columns of this schedule should indicate the total number of beds at the date of change in the number of beds.

STAFFING RATIO REPORT FOR DIRECT CARE STAFF

Only the direct care staff as defined in the ICF/MR provider guide and direct care supervisors that worked during the shift, and the total number of hours they worked for that shift should be included in this report.

Page 18

STAFFING RATIO REPORT FOR SECURE WARD STAFF

Only the secure ward staff and supervisors that worked during the shift, and the total number of hours they worked for that shift should be included in this report.

CHART OF ACCOUNTS

RESIDENT REVENUES

The Private Resident, Other Governmental Supported Resident, and Medicaid Resident revenue accounts are for routine care charges. Revenues generated by charges for ancillary services and supplies are to be included in one of the other appropriate revenue accounts.

Acct. 2120 - Private Resident - ICF/MR

This account includes revenues for routine services provided to private residents that come under the ICF/TIR classification as defined in Rule 461-17-600.

Acct. 2140 - Private Resident - Other

This account includes revenues for routine services provided to private residents that do not come under the ICF/MR, skilled, or semi-skilled classifications. The classifications and amounts should be specified on Schedule A.

Acct. 2250 - Other Governmental Supported Resident

This account includes revenues for routine services from other governmental programs, such as VA. Programs and amounts should be specified on Schedule A.

Acct. 2320 - Medicaid Resident - ICF/MR

This account includes revenues for routine services provided to Medicaid residents that are classified as ICF/MR by the Division.

Acct. 2400 - Physical Therapy

This account includes revenue for ancillary physical therapy services, not provided as part of routine care.

Acct. 2410 - Speech Therapy

This account includes revenue for ancillary speech therapy services, not provided as part of routine care.

Acct. 2420 - Occupational Therapy

This account includes revenue for ancillary occupational therapy services. not provided as part of routine care.

Acct. 2500 - Nursing Supplies

This account includes revenue for nursing supplies not provided as part of routine care.

Acct. 2510 - Prescription Drugs

This account includes revenue for prescription drugs not provided as part of routine care.

Acct. 2520 - Laboratory

This account includes revenue for laboratory work, supplies and services, not provided as part of routine care.

Acct. 2530 - X-Ray

This account includes revenue for x-ray work, supplies, and Services not provided as part of routine care.

Acct. 2600 - Barber and Beauty Shop

This account includes revenue for barber and beauty services and supplies not provided as part of routine care.

Acct. 2610 - Personal Purchase Income

This account includes revenue from resident purchases of incidental items not accounted for in any other revenue account and not provided as part of routine care.

Acct. 2700 - Miscellaneous Resident Revenue

If revenue is included in this account, items and amounts are to be specified on Schedule A.

Other Revenue

The following accounts are to be used to record revenues not as likely to come directly from residents as the foregoing revenues.

Acct. 2800 - Grants

This account includes income from grants.

Acct. 2810 - Donations

This account includes income from donations.

Acct. 2820 - Interest Income

This account includes interest income generated by loans.

Acct. 2830 - Rental Income

This account includes revenue generated by rental of equipment and facilities.

Acct. 2840 - Staff and Guest Food Sales

This account includes revenue from sale of food to staff and guests.

Acct. 2850 - Concession Income

This account includes revenue from concession sales, including candy machines, soft drink machines, and cigarette machines.

Acct. 2900 - Miscellaneous Revenue

If revenue is included in this account, items and amounts are to be specified on Schedule A.

Base and Labor Costs

The following accounts are to be used to classify expenses.

Base Costs

These accounts are for costs other than salaries and certain consulting fees.

General & Administrative

Acct. 3310 - Office Supplies and Printing

All office supplies, printing, small equipment of an administrative use not requiring capitalization, postage, printed materials including manuals and educational materials are to be included in this account.

Acct. 3510 - Legal and Accounting

Legal fees applicable to the facility and attributable to resident care are to be included in this account. Retainer fees are not a specific resident related cost and shall be adjusted as non-allowable. Legal fees attributable to a specific resident shall also be adjusted as non-allowable. Accounting and bookkeeping expenses of a non-duplicatory nature including accounting related data processing costs are also to be included in this account.

Acct. 3520 - Management fees

Management fees as defined in Rule 461-17-895 are to be included in this account.

Acct. 3530 - Donated Services

Donated services by non-paid workers as defined in Rule 461-17-810 are to be included in this account. The account should show the actual expenses in Column 1. Adjustments and reclassifications to appropriate salary accounts shall be made in Column 3. Attach worksheet to show adjustments and reclassifications.

Acct. 3610 - Communications

Telephone and telegraph expenses are to be included in this account.

Acct. 3711 - Travel - Motor Vehicle - Medical

This account includes medically related costs attributable to vehicle operation for facility and resident care use only. Personal use shall be separated from this account as an adjustment. Other expenses of auto insurance, repairs and maintenance, gas and oil, and reimbursement of actual employee expenses attributable to facility business should be included in this account. Auto allowances that are not documented by actual expenses will be reclassified to the appropriate salary or payroll account or adjusted as a non-allowable expense.

Acct. 3712 - Travel - Motor Vehicle - Non-Medical

This account includes the same kinds of costs described for Acct. 3711, Travel – Motor Vehicle - Medical, except they are not medically related. See Rule 461-17-656 of the ICF/MR provider guide.

Acct. 3721 - Travel - Other - Medical

This account includes all medically related travel expenses not related to the use of a vehicle belonging to the facility or an employee, including board and room on business trips, airline and bus tickets. These expenses should be attributable to and related to resident care or this account should be adjusted for expenses attributable to non-resident care travel.

Acct. 3722 - Travel - Other - Non-Medical

This account includes the same kinds of costs described for Acct. 3721, Travel - Other - Medical, except they are not medically related. See Rule 461-17-656 of the ICF/MR provider guide.

Acct. 3809 - Other Interest Expense

Only interest not related to purchase of facility and equipment (including vehicles) is to be included in this account.

Acct. 3810 - Advertising and Public Relations

Advertising and public relations expenses are to be included in this account. See Rule 461-17-910 for definition of non-allowable portion.

Acct. 3320 - Licenses and Dues

License and dues expenses are to be included in this account.

Acct. 3830 - Bad Debts

Bad debts associated with Title XIX recipients are allowable. All other bad debts shall be adjusted as non-allowable.

Acct. 3840 - Freight

This account includes shipping charges paid by the provider, unless they should be capitalized as part of a capital asset.

Acct. 3910 - Miscellaneous

This account includes general and administrative expenses not otherwise includable in the General and Administrative Cost Area. These expenses are to be described on Schedule A.

Shelter

Acct. 4310 - Repair and Maintenance

This account contains all material costs entailed in the maintenance and repair of the building and departmental equipment.

Acct. 4510 - Purchased Services

This account contains all expenses paid for outside services purchased in the maintenance and repair of building, building equipment and department equipment. It is also to include items such as lawn care by an outside service, security service, etc.

Acct. 4610 - Real Estate and Personal Property Taxes

Real estate and personal property tax expenses are to be included in this account.

Acct. 4620 - Rent

Rent attributable to the lease of a facility is to be included in this account.

Acct. 4630 - Lease

Lease expenses of equipment, vehicles, and other items separate from rent of a facility are to be included in this account.

Acct. 4640 - Insurance

This account includes all insurance expenses except auto insurance, which should be classified under Travel - Motor Vehicle.

Acct. 4710 - Depreciation - Land-Improvements

See Rules regarding capital assets and depreciation.

Acct. 4720 - Depreciation - Building

See Rules regarding capital assets and depreciation.

Acct. 4730 - Depreciation -Building Equipment

See Rules regarding capital assets and depreciation.

Acct. 4740 - Depreciation -Moveable Equipment

See Rules regarding capital assets and depreciation.

Acct. 4750 - Depreciation -Leasehold Improvements

See Rules regarding capital assets and depreciation.

Acct. 4809 - Interest

Interest attributable to the purchase of facility and equipment is to be included in this account.

Acct. 4910 - Miscellaneous

This account includes shelter expenses not otherwise includable in the Shelter Cost Area.

Utilities

Acct. 5610 - Heating Oil

Heating oil expense is to be included in this account.

Acct. 5620 - Gas

Gasoline for autos included in Travel - Motor Vehicles.

Acct. 5630 - Electricity

Electricity expense is to be included in this account.

Acct. 5640 - Water, Sewage and Garbage

Water, sewage and garbage expenses are to be included in this account.

Laundry

Acct. 6310 - Laundry Supplies

Laundry supplies expense is to be included in this account.

Acct. 6315 - Linen and Bedding

Linen and bedding expense is to be included in this account.

Acct. 6510 - Purchased Laundry Services

Laundry services purchased from an outside provider are to be included in this account.

Acct. 6910 - Miscellaneous

This account includes laundry costs not otherwise includable in the Laundry Cost Area.

Housekeeping

Acct. 7310 - Housekeeping Supplies

Housekeeping supplies expense is to be included in this account.

Acct. 7910 - Miscellaneous

This account includes housekeeping costs not otherwise includable in the Housekeeping Cost Area.

Dietary

Acct. 8310 - Dietary Supplies

This account includes expenses associated with the serving of food, such as utensils, paper goods, dishware and other items.

Acct. 8410 - Food

This account combines all the costs of prepared foods, meats, vegetables and all manner of food ingredients and supplements. Expenses for candy, food or beverages sold through vending machines, commissary or snack-bar are to be included in the expense account Concession Supplies.

Acct. 8910 - Miscellaneous

This account includes dietary costs not otherwise includable in the Dietary Cost Area.

Nursing Supplies and Services

Acct. 9310 - Nursing Supplies

This account includes costs of supplies used in nursing care covered in Rule 461-17-650 (3).

Acct. 9320 - Drugs and Pharmaceuticals Non-RX

This account includes costs of drugs and pharmaceuticals defined in Rule 461-17-650 (2) (f).

Acct. 9330 - Drugs and Pharmaceuticals - RX

This account includes drug prescription costs defined in Rule 461-17-655(1).

Acct. 9351 - Pharmacy Services and Supplies

Pharmacy supplies and outside services expenses are to be included in this account.

Acct. 9352 - Laboratory Services and Supplies

Laboratory supplies and outside services expenses are to be included in this account.

Acct. 9353 - X-Ray Services and Supplies

X-Ray supplies and outside services expenses are to be included in this account.

Acct. 9354 - Recreation Supplies and Services

Activities supplies and outside services expenses are to be included in this account.

Acct. 9355 - Rehabilitation Supplies and Services

Rehabilitation supplies and outside services expense are to be included in this account.

Acct. 9510 - Physician Fees

Outside physician fees are to be included in this account.

Acct. 9530 - Day Treatment Supplies and Services

Only FSRTF facilities are to use this account, which is to include day treatment supplies and services expense.

Acct. 9950 - Concession Supplies

This account includes costs associated with vending machines and similar resale items.

Acct. 9955 - Barber and Beauty Shop

This account includes barber and beauty related costs. Costs of services and supplies not meeting the definition in Rule 461-17-650(2)(g) shall be adjusted.

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Acct. 9960 - Funeral and Cemetery

Funeral and cemetery expenses are to be included in this account.

Acct. 9965 - Personal Purchases

This account includes the costs of all items purchased for resident care and excluded in Rule 461-17-650 as part of the all-inclusive rate unless specifically included in another account. These items would include, but not be limited to, incidental items defined in Rule 461-17-660 authorized for payment from resident funds, and items not routinely furnished to all residents without additional costs.

Acct. 9990 - Miscellaneous

This account includes miscellaneous supplies and services not otherwise includable in the Nursing Supplies and Services Cost Area. Items and amounts are to be listed on Schedule A.

Labor Cost

Payroll Taxes and Employee Benefits

These accounts are to include all payroll taxes and employee benefits. The total net allowable payroll taxes and employee benefits (Acct. #3200) are to be allocated to the appropriate payroll and employee benefit account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll.

Acct. 3200 - Total Employee Benefits & Taxes

This account is the total of Acct. 3210 Total Payroll Taxes and Acct. 3220 Employee Benefits.

Acct. 3210 - Total Payroll Taxes

This account includes the payroll taxes FICA, Acct. 3211, State Unemployment, Acct. 3212, Federal Unemployment, Acct. 3213, Workers' Compensation, Acct. 3214, Tri-Met, Acct. 3215, and any others.

Acct. 3211 - FICA

This account includes the FICA tax.

Acct. 3212 - State Unemployment

This account includes the State unemployment insurance tax.

Acct. 3213 - Federal Unemployment

This account includes the Federal unemployment insurance tax.

Acct. 3214 - Worker's Compensation

This account includes the Worker's Compensation tax.

Acct. 3215 - Tri-Met

This account includes the Tri-Met payroll tax.

Acct. 3216 - Payroll Tax - Other

Any amount showing in this account must be identified.

Acct. 3220 - Employee Benefits

This account includes all employee benefits, and does not include payroll taxes for unemployment insurance and state accident insurance.

Administrative Salaries

Acct. 3110 - Administrator Salary

This account includes all of the compensation received by the administrator. Other compensation including allowances and benefits not documented by specific costs, or similarly accruing to other employees of the facility are to be included in this account as a reclassification.

Acct. 3231 - Employee Benefits & Taxes

This account includes employee taxes and benefits for the administrator, including employee insurance, vacation and sick pay, and other fringe benefits not otherwise accounted for. The costs in this account are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Other - Administrative Salaries

Acct. 3120 - Assistant Administrator Salary

This account includes all compensation received by the assistant administrator. The provisions applicable to the administrator compensation apply.

Acct. 3130 - Salaries - Other Administrative

All clerical, receptionist, ward clerk and medical records personnel salaries are to be included in this account. All home office payroll allocable to the facility is to be included in this account unless it is adequately demonstrated on an attachment to the cost statement that payroll amounts belong in another payroll account.

Acct. 3232 - Employee Benefits and Taxes

This account includes benefits and taxes for the other administrative personnel. The costs in this account are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Nursing Salaries

Acct. 9110 - Salaries - DNS

Director of Nursing Service salary is to be included in this account.

Acct. 9111 - Salaries - RN

Registered Nurse salaries are to be included in this account.

Acct. 9112 - Salaries - LPN

Licensed Practical Nurse and Licensed Vocational Nurse salaries are to be included in this account.

Acct. 9291 - Employee Benefits and Taxes

This account shall include employee benefits and taxes for the DNS, RN's, and LPN's. The costs are to be allocated from Acct #3200 - Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Direct Care Salaries

Acct. 9122 - Salaries - Direct Care

Salaries for the facility's living unit personnel who train residents in activities of daily living and in the development of self-help and social skills are included in this account. This does not include salaries for other professional services included under active treatment services.

Acct. 9123 - Salaries - Direct Care Supervisors

Salaries for direct care supervisors.

Acct. 9124 - Salaries - Secure Ward Staff

Salaries for secure ward staff.

Acct. 9125 - Salaries - Secure Ward Supervisors

Salaries for secure ward supervisors.

Acct. 9292 - Employee Benefits and Taxes

This account includes employee benefits and taxes for direct care staff. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Other Salaries

Acct. 4110 - Repair and Maintenance Salaries

This account includes payroll for services related to repair, maintenance and plant operation.

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Acct. 6110 - Laundry Salaries

Laundry salaries are to be included in this account.

Acct. 7110 - Housekeeping Salaries

Janitorial salaries and housekeeping salaries are to be included in this account.

Acct. 8110 - Dietary Salaries

Dietary salaries are to be included in this account.

Acct. 9130 - Salaries - Physician

Physician salaries, exclusive of physician fees and consulting services, are to be included in this account.

Acct. 9131 - Salaries - Pharmacy

Pharmacy salaries are to be included in this account.

Acct. 9132 - Salaries - Laboratory

Laboratory salaries are to be included in this account.

Acct. 9133 - Salaries - X-Ray

X-ray salaries are to be included in this account.

Acct. 9134 - Salaries - Activities (Occupational)

Activities (occupational) salaries are to be included in this account.

Acct. 9135 - Salaries - Rehabilitation

Rehabilitation salaries are to be placed in this account.

Acct. 9140 - Salaries - Religious

Religious salaries are to be included in this account.

Acct. 9148 - Salaries - Receiving Warehouse

Only receiving warehouse salaries incurred by FSRTF's are to be included in this account.

Acct. 9149 - Salaries - Other

This account includes Nursing Service Salaries not otherwise includable in the Nursing Service Cost Area. Purchased nursing services are to also be included in this account. Items and amounts are to be specified on Schedule A.

Acct. 9296 - Employee Benefits and Taxes

This account includes benefits and taxes for the employees listed in the cost category. The costs are to be allocated from Acct. #3200 Total Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Active Treatment Services

These accounts include all special programs, except Day Program service costs incurred by FSRTF'S, and professional medical services, except Medical Service costs incurred by FSRTF'S. Included are costs for consultation, treatment and evaluations not paid for separately by the Division. Expenses not required for certification shall be adjusted as non-allowable.

Acct. 9150 - Qualified Mental Retardation Professional

Acct. 9151 - Registered Nurse Consultant (SRTF Only)

Acct. 9152 - Psychologist

Acct. 9153 - Social Worker

Acct. 9154 - Speech Therapist

Acct. 9156 - Occupational Therapist

Acct. 9157 - Recreation Therapist

Acct. 9158 - Physical Therapist

Acct. 9159 - Dietitian

Acct. 9160 - Dentist

Acct. 9161 - Pharmacist

Acct. 9162 - Skill Trainer/Program Coordinator

Acct. 9170 - Other Medical Consultants

Acct. 9297 - Employee Benefits and Taxes

This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Medical Services

These accounts include only medical service program costs incurred by FSRTF's.

Acct. 9180 - Physician Services

Acct. 9181 - Pharmacy Services

Acct. 9182 - Laboratory Services

Acct. 9183 - X-Ray Services

Acct. 9186 - Nursing Services

Acct. 9187 - Dental Services

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Acct. 9188 - Central Supply Services

Acct. 9298 - Employee Benefits and Taxes

This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Day Program Services

These accounts include only Day Program service costs incurred by FSRTF'S.

Acct. 9190 - Day Program Services

Acct. 9299 - Employee Benefits and Taxes

This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

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State of Oregon
Department of Human Resources
ADULT & FAMILY SERVICES DIVISION

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ICF/MR COST STATEMENT

NAME ON LICENSE _____ PROVIDER NO. MS

MAILING ADDRESS

STREET ADDRESS _____ AFS BRANCH

CITY, STATE, ZIP _____ PHONE

ACCOUNTING AND OTHER DATA

PERIOD OF THIS REPORT: FROM _____ THROUGH

NUMBER OF DAYS IN ABOVE PERIOD _____ ENDING MONTH OF NORMAL/FISCAL YEAR _____

TYPE OF ORGANIZATION: INDIVIDUAL PARTNERSHIP PROPRIETARY CORPORATION

NON-PROFIT CORPORATION OTHER: _____

NAME OF HOME OFFICE, IF ANY

ADDRESS _____ PHONE

ACCOUNTANT'S NAME AND/OR FIRM NAME

ADDRESS _____ PHONE

THE BOOKS ARE KEPT AT:

PUBLIC BILLING RATES

DURING THE TIME PERIOD COVERED BY THIS COST STATEMENT, THE RATES THAT WE CHARGED OUR PRIVATE RESIDENTS FOR ICF/MR SERVICES WERE:

INCLUSIVE DATES	#1	CLASSIFICATION UNDER WHICH RATES WERE CHARGED*				#6
		#2	#3	#4	#5	

*Submit an appropriate definition of each classification on a separate schedule and submit a copy with this cost report.

This cost statement has been prepared from information furnished without independent examination by me (us). Since my (our) procedures did not constitute an examination made in accordance with generally accepted auditing standards, I (we) do not express an opinion on these statements.

Title Date

Under penalties of law, I declare that I have examined this cost statement, including accompanying schedules and statements, and that this material is complete, accurate and true and prepared in accordance with the rules of the Adult and Family Services Division of the State of Oregon. I understand that any false statement, claim or document or concealment of material fact herein may be prosecuted under applicable federal or state law.

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IDENTIFICATION OF OWNERS, PARTNERS, LESSEES, STOCKHOLDERS,
 ETC., WITH 5% OR MORE OWNERSHIP IN THIS FACILITY

NAME	TITLE	RESIDENCE (CITY & STATE)	%

100

COMPENSATION OF OWNERS, PARTNERS, FAMILY MEMBERS, RELATIVES,
 LESSEES, STOCKHOLDERS, OFFICERS

	NAME	RELATIONSHIP	SERVICE(S) PERFORMED
1			
2			
3			
4			
5			

	% of customary work week devoted to this facility business	Compensation amount included in this cost statement (omit ¢)	Account number(s) where compensation is included
1A			
2A			
3A			
4A			
5A			

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OTHER FACILITIES/BUSINESSES FOR WHICH THE OWNERS
 EXERCISE A 5% OR MORE OWNERSHIP OR CONTROL

OWNER NAME	FACILITY/BUSINESS NAME	%	NATURE OF BUSINESS

ADMINISTRATOR SUMMARY

NAME	DATE OF SERVICE
<u>Current Administrator</u>	

RELATED ORGANIZATIONS*

(*Defined in Rule 461-17-600 of the ICF/MR-Provider Guide)

<u>NAME</u>	<u>DESCRIPTION OF SERVICES, FACILITIES, AND SUPPLIES</u>	<u>NATURE OF RELATIONSHIP</u>

Cost of goods or services to the related organization and charge to the facility shall be listed by account on Schedule A.

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SPECIAL NOTES PERTAINING TO COST STATEMENT

DATA ON FACILITIES & EQUIPMENT

1 DATE THIS FACILITY ACQUIRED _____ APPROXIMATE AGE OF FACILITY

2 LAND&BUILDING: __OWNED __LEASED EQUIPMENT: __OWNED __LEASED

IF LEASED, LESSOR'S NAME & ADDRESS:

IF LEASED, LESSOR'S NAME & ADDRESS:

4 A COPY OF THE FACILITY LEASE, INCLUDING AMENDMENTS, PLUS A COPY OF YOUR FEDERAL OR OTHER APPLICABLE DEPRECIATION SCHEDULES ARE REQUIRED.

5 REASON IF FACILITY LEASE NOT ATTACHED _____

6 REASON IF DEPRECIATION SCHEDULE NOT ATTACHED

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REVENUE

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS REVENUE	+	(2) HOME OFFICE REVENUE	+	ADJ.	(3) & RECLASS.	=	(4) NET PROVIDER REVENUE
<u>RESIDENT REVENUES</u>									
<u>2120</u>	Private Resident ICF/MR								
<u>2140</u>	Private Resident-Other (Sch. A)								
<u>2250</u>	Other Governmental Supported Resident (Sch.A)								
<u>2320</u>	Medicaid Resident - ICF/MR								
<u>2400</u>	Physical Therapy								
<u>2410</u>	Speech Therapy								
<u>2420</u>	Occupational Therapy								
<u>2500</u>	Nursing Supplies								
<u>2510</u>	Prescription Drugs								
<u>2520</u>	Laboratory								
<u>2530</u>	X-Ray								
<u>2600</u>	Barber & Beauty Shop								
<u>2610</u>	Personal Purchase Income								
<u>2700</u>	Miscellaneous Resident Revenue (Sch. A)								
<u>OTHER REVENUE</u>									
<u>2800</u>	Grants								
<u>2810</u>	Donations								
<u>2820</u>	Interest Income								
<u>2830</u>	Rental Income - Facilities & Equip.								
<u>2840</u>	Staff & Guest Food Sales								
<u>2850</u>	Concession Income								
<u>2900</u>	Miscellaneous Revenue (Sch. A)								
TOTAL REVENUES									

Net Income per ICF/MR Cost Statement _____
 Net Income per IRS Report _____
 Difference if any (Reconcile on Sch. A) _____

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SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+	(2) HOME AND RECLASSIFICATION	+	(3) ADJUSTMENTS NET ALLOWABLE EXPENSES	=	(4)
<u>GENERAL & ADMINISTRATIVE</u>								
3310	Office Supplies & Printing							
3510	Legal & Accounting							
3520	Management Fees							
3530	Donated Services							
3610	Communications							
3711	Travel-Motor Vehicle-Medical							
3712	Travel-Motor Vehicle-Non-Medical							
3721	Travel-Other-Medical							
3722	Travel-Other-Non-Medical							
3809	Other Interest Expense							
3810	Advertising & Public Relations							
3820	Licenses & Dues							
3830	Bad Debts							
3840	Freight							
3910	Miscellaneous (Sch. A)							
	TOTAL GENERAL & ADMINISTRATIVE							
<u>SHELTER</u>								
4310	Repair & Maintenance Supplies							
4510	Purchased Services							
4610	Real Estate & Personal Property Taxes							
4620	Rent							
4630	Lease							
4640	Insurance							
4710	Depreciation-Land Improvements							
4720	Depreciation-Building							
4730	Depreciation-Bldg. Equip							
4740	Depreciation-Moveable Equip.							
4750	Depreciation-Leasehold Improvements							
4809	Interest							
4910	Miscellaneous (Sch. A)							
	TOTAL SHELTER							
<u>UTILITIES</u>								
5610	Heating Oil							
5620	Gas							
5630	Electricity							
5640	Water, Sewage & Garbage							
	TOTAL UTILITIES							

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SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) + FACILITY GROSS EXPENSE	(2) + HOME OFFICE EXPENSE	(3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET EXPENSES	ALLOWABLE
LAUNDRY						
6310	Laundry Supplies					
6315	Linen & Bedding					
6510	Purchased Laundry Services					
6910	Miscellaneous (Sch. A)					
	TOTAL LAUNDRY					
HOUSEKEEPING						
7310	Housekeeping Supplies					
7910	Miscellaneous (Sch. A)					
	TOTAL HOUSEKEEPING					
DIETARY						
8310	Dietary Supplies					
8410	Food					
8910	Miscellaneous (Sch. A)					
	TOTAL DIETARY					
NURSING SUPPLIES & SERVICES						
9310	Nursing Supplies					
9320	Drugs & Pharmaceuticals Non-Prescription					
9330	Drugs & Pharmaceutical Prescription Drugs					
9351	Pharmacy Services & Supplies					
9352	Lab Services & Supplies					
9353	X-Ray Services & Supplies					
9354	Recreational Supplies Services					
9355	Rehabilitation Supplies & Services					
9510	Physician Fees					
9530	Day Treatment Supplies & Services (FSRTF Only)					
9950	Concession Supplies					
9955	Barber & Beauty Shop					
9960	Funeral & Cemetery					
9965	Personal Purchases					
9990	Miscellaneous (Sch. A)					
	TOTAL NURSING SUPPLIES & SERVICES					
	TOTAL BASE COSTS					

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SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) OFFICE EXPENSE	+ HOME	(3) AND RECLASSIFICATION	ADJUSTMENTS	= (4) ALLOWABLE EXPENSES	NET
ADMINISTRATOR SALARIES								
3110	Administrator Salary							
3231	Employee Benefits & Taxes							
	TOTAL							
OTHER ADMINISTRATIVE SALARIES								
3120	Salary-Ass't. Administrator							
3130	Salaries-Other Admin.							
3232	Employee Benefits & Taxes							
	TOTAL							
NURSING SALARIES								
9110	Salaries-DNS							
9111	Salaries-RN							
9112	Salaries-LPN							
9291	Employee Benefits & Taxes							
	TOTAL							
DIRECT CARE SALARIES								
9122	Salaries-Direct Care Staff							
9123	Salaries-Direct Care Supervisors							
9124	Salaries-Secure Ward Staff							
9125	Salaries-Secure Ward Supervisors							
9292	Employee Benefits & Taxes							
	TOTAL							
OTHER SALARIES								
4110	Repair & Maintenance Salaries							
6110	Laundry Salaries							
7110	Housekeeping Salaries							
8110	Dietary Salaries							
9130	Salaries-Physician							
9131	Salaries-Pharmacy							
9132	Salaries-Laboratory							
9133	Salaries-X-Ray							
9134	Salaries-Activities (Occupational)							
9135	Salaries-Rehabilitation							
9140	Salaries-Religious							
9148	Salaries-Receiving Warehouse (FSRTE only)							
9149	Salaries-Other (Sch. A)							
9296	Employee Benefits & Taxes;							
	TOTAL							

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SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ HOME EXPENSE	(2) OFFICE	+ ADJUSTMENTS AND RECLASSIFICATION	(3)	=	(4) NET EXPENSES ALLOWABLE
<u>ACTIVE TREATMENT SERVICES</u>								
<u>9150</u>	<u>Qualified Mental Retardation Professional</u>							
<u>9151</u>	<u>Registered Nurse Consultant (SRTF Only)</u>							
<u>9152</u>	<u>Psychologist</u>							
<u>9153</u>	<u>Social Worker</u>							
<u>9154</u>	<u>Speech Therapist</u>							
<u>9156</u>	<u>Occupational Therapist</u>							
<u>9157</u>	<u>Recreational Therapist</u>							
<u>9158</u>	<u>Physical Therapist</u>							
<u>9159</u>	<u>Dietitian</u>							
<u>9160</u>	<u>Dentist</u>							
<u>9161</u>	<u>Pharmacist</u>							
<u>9162</u>	<u>Skill Trainer/Program Coord.</u>							
<u>9170</u>	<u>Other Medical Consultants (Sch. A)</u>							
<u>9297</u>	<u>Employee Benefits & Taxes</u>							
	TOTAL							
<u>MEDICAL SERVICES (FSRTF only)</u>								
<u>9180</u>	<u>Physician Services</u>							
<u>9181</u>	<u>Pharmacy Services</u>							
<u>9182</u>	<u>Laboratory Services</u>							
<u>9183</u>	<u>X-Ray Services</u>							
<u>9186</u>	<u>Nursing Services</u>							
<u>9187</u>	<u>Dental Services</u>							
<u>9188</u>	<u>Central Supply Services</u>							
<u>9298</u>	<u>Employee Benefits & Taxes</u>							
	TOTAL							
<u>DAY PROGRAM SERVICES (FSRTF only)</u>								
<u>9190</u>	<u>Day Program Services</u>							
<u>9299</u>	<u>Employee Benefits & Taxes</u>							
	TOTAL							
	TOTAL LABOR COSTS							
	TOTAL BASE & LABOR COSTS							

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SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

ACCOUNT #	ACCOUNT	(1)	+	(2)	+	(3)	=	(4)
		FACILITY GROSS EXPENSE		HOME OFFICE EXPENSE		ADJUSTMENTS AND RECLASSIFICATION		NET ALLOWABLE EXPENSES
3211	<u>FICA</u>							
3212	<u>State Unemployment</u>							
3213	<u>Federal Unemployment</u>							
3214	<u>Worker's Compensation</u>							
3215	<u>Tri-Met</u>							
3216	<u>Other (Specify)</u>							
3210	TOTAL PAYROLL TAXES							
3200	TOTAL EMPLOYEE BENEFITS & TAXES							

NOTE: The net allowable payroll taxes and employee benefits (column 4 above) are to be allocated to the appropriate sub-accounts in each "Labor Cost" category by actual cost, or by percentage of payroll category amount to the total facility payroll.

RETURN ON OWNER'S EQUITY CALCUIATION

_____ Net Owner's Equity at Beginning of Period

_____ Net Owner's Equity at End of Period

_____ + 2 = _____ Average Owner's Equity

x _____ Rate of Return

= _____ Return on Owner's Equity

Note: The return on owner's equity is entered on Page 12, or, if an allocation is required, on Page 13.

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		<u>BALANCE SHEET</u>					
ACCOUNT #	ACCOUNT	(1)	+	(2)	+	(3) =	(4)
		FACILITY	OFFICE	HOME	RECLASS.	ADJ. &	NET
<u>1101</u>	Cash on Hand						
<u>1102</u>	Cash in Bank						
<u>1103</u>	Cash in Savings						
<u>1150</u>	Accounts Receivable						
<u>1160</u>	Notes Receivable						
<u>1169</u>	Provision for Doubtful Accounts						
<u>1170</u>	Employee Advances						
<u>1200</u>	Inventory-Nursing Supplies						
<u>1201</u>	Inventory-Food						
<u>1202</u>	Inventory-Other						
<u>1250</u>	Prepaid Expenses (Sch. A)						
<u>1270</u>	Other Current Assets (Sch. A)						
<u>1310</u>	Land						
<u>1320</u>	Land Improvements						
<u>1321</u>	Accumulated Depreciation Land Improvements						
<u>1330</u>	Buildings						
<u>1331</u>	Accumulated Depreciation-Bldg.						
<u>1340</u>	Equipment-Bldg. Fixed						
<u>1341</u>	Accumulated Depreciation-Equip. Bldg.						
<u>1350</u>	Equipment-Moveable						
<u>1351</u>	Accumulated Depreciation - Equip. Moveable						
<u>1370</u>	Leasehold Improvements						
<u>1371</u>	Accumulated Amortization- Lease Improvements						
<u>1400</u>	Investments (Sch. A)						
<u>1470</u>	Other L/T Assets (Sch. A)						
	TOTAL ASSETS						

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BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) FACILITY	+ OFFICE	(2) HOME	+ RECLASS.	(3) ADJ. &	= NET	(4)
LIABILITIES AND CAPITAL								
1510	Accounts Payable							
1550	Notes Payable-Other							
1560	Notes Payable - Owners							
1570	Accrued Interest Payable							
1600	Payroll Payable							
1610	Payroll Taxes Payable							
1620	Other Payroll Deductions Payable							
1630	Deferred Income (Sch. A)							
1670	Other Current Liabilities (Sch. A)							
1810	Long-Term Mortgage Payable -							
1850	Long-Term Notes Payable - Other							
1860	Long-Term Notes Payable - Owners							
1870	Other Long-Term Liabilities (Sch. A)							
	TOTAL LIABILITIES							
1910	Capital Stock							
1950	Retained Earnings							
1960	Capital Account - Proprietor or Partners							
1970	Drawing Account - Proprietor or Partners							
1980	Net Profit (loss) year to date							
	TOTAL CAPITAL							
	TOTAL LIABILITIES & CAPITAL							

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**COST AREA ALLOCATIONS SCHEDULE FOR FACILITIES
 WITH OTHER REVENUE PRODUCING PROGRAMS**

If there is no revenue producing activity related to non-allowable costs which generates revenue in excess of 2% of the total gross expenses, check here do not complete this page, and continue with the next page.
 If a different allocation method is used, an explanation of the method and the reason for its use must be provided on page 4.
 Each level-of-care column should contain the resident days or square feet related to that level-of-care as designated in each cost area.
 For each cost area, the allocation base is the total of the level-of-care columns for that cost area.
 The multiplier is the net cost area expense divided by the allocation base.
 The product of the multiplier and the ICF/MR Level-of-Care column by cost area is entered on the "Allocated Costs" schedule on page 14.

COST AREA/ DESIGNATED <u>ALLOCATION METHOD</u>	ICF/MR	Level-of-Care		Allocation Base	Net Cost Area Expense	Multiplier
		Other (Specify)	Other (Specify)			
Gen. & Admin. <u>Resident Days</u>						Shelter
<u>Square Footage</u>						Utilities Square
<u>Footage</u>						Laundry Resident Days
Housekeeping <u>Square Footage</u>						
Dietary <u>Resident Days</u>						
Nursing Supplies & Services <u>Resident Days</u>						
Admin. Salaries <u>Resident Days</u>						
Other Admin. Salaries <u>Resident Days</u>						
Nursing Salaries <u>Actual Payroll</u>						
Direct Care Salaries <u>Actual Payroll</u>						
Other Salaries <u>Actual Payroll</u>						
Active Treatment Services <u>Actual Payroll</u>						
Medical Services <u>Actual Payroll</u>						
Day Program Services <u>Actual Payroll</u>						
Return on Equity <u>Resident Days</u>						

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ALLOCATED COSTS

Cost Areas	ICF/MR
<u>BASE COSTS</u> <u>General & Administrative</u> <u>Shelter</u> <u>Utilities</u> <u>Laundry</u> <u>Housekeeping</u> <u>Dietary</u> <u>Nursing Supplies & Services</u>	
TOTAL BASE COSTS	
<u>LABOR COSTS</u> <u>Administrator Salaries</u> <u>Other Administrative Salaries</u> <u>Nursing Salaries</u> <u>Direct Care Salaries</u> <u>Other Salaries</u> <u>Active Treatment Services</u> <u>Medical Services</u> <u>Day Program Services</u>	
TOTAL LABOR COSTS	
<u>RETURN ON EQUITY</u>	
GRAND TOTAL	

GRAND TOTAL = _____ ICF/MR Cost per Day
 ICF/MR Resident Days

TN# 80-31
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SCHEDULE A

EXPLANATION OF MISCELLANEOUS ACCOUNTS

<u>ACCT. #</u>	<u>EXPLANATION</u>	<u>AMOUNT</u>	<u>ACCT. #</u>	<u>EXPLANATION</u>	<u>AMOUNT</u>

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Resident Classification Report
Resident Days By Classification and B Level-Of-Care

Month	ICF/MR											
	A		A-I-3		S		B		C		TOTAL	Other (Specify)
	AFS	Other	AFS	Other	AFS	Other	AFS	Other	AFS	Other		
<u>January</u>												
<u>February</u>												
<u>March</u>												
<u>April</u>												
<u>May</u>												
<u>June</u>												
<u>July</u>												
<u>August</u>												
<u>Sept.</u>												
<u>Oct.</u>												<u>October</u>
<u>Nov.</u>												
<u>Dec.</u>												
TOTAL												

Month	<u>Resident Days by licensed Bed</u>				
	<u>Designated ICF/MR Area</u>			Other (Specify)	Other (Specify)
	<u>AFS</u>	<u>Other</u>	<u>Total</u>		
<u>January</u>					
<u>February</u>					
<u>March</u>					
<u>May</u>					
<u>June</u>					
<u>July</u>					
<u>August</u>					
<u>Sept.</u>					
<u>October</u>					
<u>Nov.</u>					
<u>Dec.</u>					
TOTAL					

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Bed Capacity

	Designated ICF/MR Area			Other (Specify)			Other (Specify)		
	Beginning	Change	Change	Beginning	Change	Change	Beginning	Change	Change
<u>Licensed Bed Capacity</u>									
<u>Certificate of Need Capacity</u>									
<u>Available Capacity</u>									
<u>Date Changed</u>									

STAFFING RATIO REPORT
OR DIRECT CARE STAFF*

MONTH	SHIFT											
	1 st		2 nd				3 rd					
	No. of Direct Care		No. of Hrs. Worked		No. of Direct Care		No. of Hrs. Worked		No. of Direct Care		No. of Hrs. Worked	
	Staffs	Sups.	Staff	Sups.	Staff	Sups.	Staff	Sups.	Staff	Sups.	Staff	Sups.
<u>January</u>												
<u>February</u>												
<u>March</u>												
<u>April</u>												
<u>May</u>												
<u>June</u>												
<u>July</u>												
<u>August</u>												
<u>September</u>												
<u>October</u>												
<u>November</u>												
<u>December</u>												

*Direct Care Staff - See ICF/MR Provider Guide for Definition.

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STAFFING RATIO REPORT
FOR SECURE WARD STAFF

SHIFT <u>3rd</u>					<u>1st</u>				<u>2nd</u>			
	No. of Secure Ward		No. of Hrs. Worked		No. of Secure Ward		No. of Hrs. Worked		No. of Secure Ward		No. of Hrs. Worked	
	Staffs	Sups.	Staff	Subs.	Staff	Sups.	Staff.	Sups	Staff	Sups.	Staff	Sups.
<u>January</u>												
<u>February</u>												
<u>March</u>												
<u>April</u>												
<u>May</u>												
<u>June</u>												
<u>July</u>												
<u>August</u>												
<u>September</u>												
<u>October</u>												
<u>November</u>												
<u>December</u>												

DEFINITION OF A CLAIM

- (1) For nursing facility services (SNF, ICF, ICF/HA, ICF-MR) and state mental hospital services (MI) and non-ancillary charges for private psychiatric hospital services, a claim is a line item on the invoice (AFS 403).
- (2) For all other services, a claim is an invoice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: OREGON

Requirements for Third Party Liability -
Identifying Liable Resources

- (1) The requirements in 433.138(f) is met, as follows:
- A. The frequency of the data exchange with the Employment Division (SWICA) is quarterly.
 - B. The frequency of the data exchange with Title IV-A is daily.
 - C. The frequency of the data exchange with the Motor Vehicle Division for accident report data is monthly.
 - D. The frequency of diagnosis and trauma code edits is daily.
 - E. The frequency of the data exchange with Worker's Compensation is monthly.

TN No. 90-15
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Approval Date 12/12/90

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(2) The requirement in 433.138(g)(1)(ii) is met, as follows:

A. SWICA

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds \$450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow-up. These forms are used to verify earnings and to gather health insurance information.

For wages paid on or after January 1, 1990, employers in Oregon are required to furnish the Employment Division with information about health insurance coverage offered to employees or to their dependents. The Employment Division will gather the information and pass it to the Adult and Family Services Division on a quarterly basis. The IV-D Agency will develop the medical insurance information as part of the medical support enforcement activities and will pass the information to the Title XIX Agency.

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B. Title IV-A

Health insurance information is passed to the Title XIX Agency via the AFS 415H form on a daily basis. Health insurance information is gathered, but not limited to, initial application and each redetermination.

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds \$450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow-up. These forms are used to verify earnings and gather health insurance information.

On a monthly basis, a match is made with the health insurance codes on the CMS system and the third party resources on the MMIS TPR file. A report is generated when there is a discrepancy so that the correct resource information is available for processing claims.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State/Territory: OREGON

- (3) The requirement in 433.138(g)(2)(ii) is met, as follows:
- A. Health Insurance
Oregon Health Authority has an Agreement with the Department of Human Services staff that obtain health insurance information from applicants for and recipients of Medicaid. Such information is gathered during the initial application for assistance and at each subsequent redetermination of eligibility, or at any other time that new information becomes known. Information may include, but is not limited to, the policy holder's name and social security number, the group or plan number, the policy or identification number, and the name and address of the insurance company.

Eligibility staff in branch offices of these Divisions and in Type B AAA offices are responsible for assuring that all available information is recorded on a designated Form (DHS 415H), and sending a copy of the completed form to the Health Insurance Group . The branch office retains the original form in the client's case record file.

The Health Insurance Group staff verify the information on the form and then enter the information into the MMIS Recipient Subsystem, Third Party Liability (TPL) File. If the branch enters a Medicare health insurance code (HIC) on the eligibility file, the Medicare insurance information is electronically transferred to the Medicare file in MMIS.

Third Party Health insurance information may also be identified by staff, through such sources as the Title IV-D Child Support Program, BENDEX, DEERS, or provider billings or refunds that indicate health insurance. In such cases, Health Insurance Group staff obtain all available information, and enter the information into the MMIS Third Party Liability file. The Buy-In Unit verifies the electronically transferred Medicare insurance in the Medicare file.

The MMIS System uses the third party health insurance information in processing claims, in accordance with 433.139(b) through (f).

MMIS generates monthly reports to the Health Insurance Group and the Medical Payment Recovery Unit for review of recovery potential whenever new insurance is added and whenever there is a change in the effective date of known insurance.

TN No. 11-01

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Supersedes TN No. 94-9

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

The time frame for completing this process, from the date that Division staff first discover health insurance information until the information appears on Report # WMMRO26R-A, is 60 days.

The written agreement between AFS and SDSD providers that SDSD will collect health insurance information and transmit this information to AFS.

The written agreement between AFS and CSD providers that CSD will collect health insurance information and transmit this information to AFS.

TN No. 94-009

Supersedes

TN No.

Approval Date 6/10/94

Effective Date 4/1/94

B. Worker's Compensation

Oregon's Medicaid program is in the process of implementing a data exchange with Workers' Compensation. Once this match is implemented, we will update this item.

During the implementation of this data match, we will use the data match that provides employment-related health insurance as described in section II-A above. In addition, the IV-D agency will continue to conduct a data match with Workers' Compensation and perform medical support enforcement activities involving the absent parents.

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(4) The requirement in 433.138(g)(3)(i) is met, as follows:

A. Motor Vehicle Accident Report data match

The Department of Motor Vehicles provides a monthly transaction tape containing motor vehicle accident report information. These transactions are matched with clients on the MMIS Recipient file by name and date of birth. Clients with an eligibility period on or after the date of the accident are matched. The matches are then run by the Expense Avoidance file and any record that has already been followed-up will be eliminated to avoid duplication of effort.

Information from the DMV transaction tape and from MMIS will be downloaded from the mainframe to a floppy disk. The floppy disk is loaded into the Third Party Recovery Unit's DMV Accident Data Base File on a personal computer. This data base is used for generating letters and is used for tickler purposes. The follow-up steps are as follows:

- a) The Third Party Recovery Unit sends a letter to each client, asking for information about the accident. An AFS 451 is sent with each letter. This is the form that clients use to report motor vehicle accident information. The data base is updated when the response is received and serves as the tickler file to keep track of those situations where no response is received within the initial 30 days.
- b) If no response is received within 30 days, a follow-up letter to the recipient is generated from the data base.
- c) If no response is received within 30 days of the second letter, the Third Party Recovery unit obtains a copy of the accident report from the Division of Motor Vehicles.

(5) The requirement in 433.138(g)(3)(iii) is met, as follows:

A. Motor Vehicle Accident Report data match

After follow-up, all information that identifies legally liable third party resources is entered by staff from the Third Party Recovery Unit on the MMIS Third Party Resource File or the MMI-S Expense Avoidance File; The MMIS System automatically enters an indicator in the appropriate field on the MMIS Recipient File. The time frame for incorporating the information is 60 days.

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(6) The requirement in 433.138(g)(4)(i) is met, as follows:

Claims which meet the following edit criteria are suspended on a daily basis:

Through MMIS edit 417, a report is generated for claims that contain diagnosis codes 800 through 999, with the exception of code 994.6. This edit reports all inpatient hospital claims where the billed amount exceeds zero, and outpatient hospital and medical claims where the billed amount exceeds \$250 dollars.

Edit 406 will suspend claims which indicate auto related, with no form AFS 451 information on the Expense Avoidance file.

1) A worksheet/report is generated and is sent to the Third Party Recovery Unit. The worksheets are reviewed, with priority given to the following:

- A. Claims with auto accident indicators.
- B. Claims with the following diagnosis codes: 810.00, 815.03, 821.00, 850.00, 922.10, and 997.30.

This sub-group of diagnosis codes represents injuries most likely to yield recoveries based on prior experience. On an annual basis the Third Party Recovery Unit will review the related trauma diagnosis codes for medical recoveries which exceed \$5000, to determine which trauma diagnosis codes should receive the highest priority for follow-up activities for the following year.

- C. Claims containing diagnosis codes beginning with E, unless such claims clearly do not represent a liability situation.
- D. Claims exceeding \$10,000, which are not related to late effects of surgery, unless such claims clearly do not represent a liability situation.

The Third Party Recovery Unit follows-up all claims included in A -D above, with written correspondence to the client. The client is provided with an AFS 451/AFS 451NV form to complete. The AFS 451/AFS 451NV are used to report accident information to the agency. If no response is received within 30 days, a second letter is sent to the client. If there is no current address for the client, a memo is sent to the branch worker requesting assistance. on a case by case basis, information may be obtained from the medical provider.

The completed AFS 451/AFS 451NV form is reviewed by the Third Party Recovery Unit. Liens are filed in liability situations and the information incorporated into the MMIS Expense Avoidance File. In addition to lienable situations, all claims suspended are reviewed for possible other insurance. All third party resource information identified is incorporated into the MMIS third party data base files. The MMIS Recipient file is updated with an indicator whenever a Third Party Resource file or an Expense Avoidance file is created. The information is used by the MMIS system to process claims in accordance with 433.139(b) through (f).

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(7) The requirement in 433.138(g)(4)(iii) is met, as follows:

After follow-up, all information that identifies legally liable third party resources is incorporated into the Third Party Recovery Unit, the MMIS Recipient File, and either the MMIS Expense Avoidance File or the MMIS Third Party Resource File, within 60 days.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: OREGON

State Laws Requiring Third Parties to Provide Coverage Eligibility and Claims Data

1902(a)(25)(I) The State of Oregon has enacted laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data of 1902(a)(25)(I) of the Social Security Act. The Oregon law became effective June 20, 2007.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

Requirements for Third Party Liability –
Payment of Claims

- 1) The requirement in 433.139(b)(3)(ii)(C) is met, as follows:

Oregon Administrative Rules and Statutes require providers to bill third parties prior to billing the state Medicaid Agency for medical services provided to Medicaid recipients. Oregon's MMIS has third party edits which prevent the payment of claims when third party insurance is active on the date of service. Medical providers use a third party resource (TPR) explanation code on the claim to communicate that the service involves insurance through the absent parent in a IV-D enforcement case, and that 30 days have lapsed since the date of service, and that the provider has not received payment from the third party resource. The MMIS system will edit for the 30 day requirement. If less than 30 days have lapsed, the claim will be rejected.

The same method is used to meet the requirements contained in Section 433.139(b)(3)(i).

State laws are in effect that require third parties to comply with the provisions of 1902(a)(25)(I) of the Social Security Act, including those which require third parties to provide the state with coverage, eligibility, and claims data.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

Requirements for Third Party Liability –
Payment of Claims

2) The requirement in 433.139(f)(2) is met, as follows:

Where the TPL file in the Medicaid Management Eligibility System (MMIS) has active third party insurance coverage, claims are cost-avoided. In the instances, when third party insurance is not known until after the state has paid a claim the state Medicaid Agency will seek recovery from the third party payer.

After the TPL file is updated in MMIS, recovery efforts are initiated systematically with the primary payer. This process includes sending up to three billing letters within a 120 day window from the date the third party insurance record is created in MMIS. If the payer does not pay our claim, the state Medicaid Agency will review the threshold limits to determine if it is cost effective to continue to pursue the claim amount.

The Medical Payment Recovery Unit (MPR) initially pursues all fee-for-service claims, however there are times when it may not be cost-effective to continue to pursue an unpaid or small dollar claim that is under \$250.00. In those instances, MPR may choose to conduct a cost-effectiveness test to consider the administrative expense vs the likelihood of recovery for the claim. If the recovery amount that can reasonably be expected is less than the administrative cost to pursue the claim, the claim may not be pursued.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

Requirements for Third Party Liability –
Payment of Claims

- 3) The requirement in 433.139(f)(3) is met, as follows:

Oregon Medicaid does not accumulate billings by dollar amount or period of time. The weekly Post Payment Recovery System billing cycle is run immediately following the weekly MMIS claims cycle. All fee-for-service bills, regardless of amount of the claim, are billed each month unless payment is not received at which point the Medical Payment Recovery Unit may choose to conduct a cost-effectiveness test for all unpaid claims under \$250.00 to determine if it is cost effective to continue pursuit of payment. All recoveries are sought within the time limits specified in 433.139(d).

State of Oregon

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Attachment 4.22-B
Page 1-c

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

Requirements for Third Party Liability –
Payment of Claims

4) Compliance 42 CFR 433.139(b)(3), SSA Section 1902(a)(25)(E)&(F)

Oregon complies with the following requirements:

1. Apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services;
2. Make payments without regard to potential TPL for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days; and
3. Make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.

TN No. 22-0010
Supersedes TN No. NEW

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Effective Date: 4/1/22

THIRD PARTY LIABILITY: Payment of Health Insurance Premiums

In accord with Section 1903(a)(1) of the Act, Oregon will on a case-by-case basis pay health insurance premiums to establish or maintain coverage for Medical Assistance recipients when it is determined to be cost beneficial. Examples are:

1. When the recipient was recently separated from employment due to a layoff, medical condition or pregnancy, and retains the option to continue with the existing health coverage through the former employer.
2. When the recipient is a dependent of an employed parent or other liable party, with option to purchase such coverage.

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OMB NO.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans
	See attached

TN No. 92-3

Supersedes

TN No. __

Approval Date 4/8/92

Effective Date 1/1/92

HCFA ID: 7985E

Third Party Liability: Payment of Group Health Plan Premiums

In accord with Section 1906 of the Act, implementing Section 4402 of OBRA of 1990, Oregon requires mandatory enrollment of Medicaid recipients in cost effective group health plans as a condition of Medicaid eligibility, except for an individual who is unable to enroll on his/her own behalf. Oregon pays the group health insurance premium for Medicaid individuals if cost effective. Oregon may also pay the premium for non-Medicaid individuals if cost effective and if it is necessary in order to enroll the Medicaid recipient in the group health plan. Oregon pays, subject to state payment rates, deductibles, coinsurance and other cost sharing obligations under the group health plan for Medicaid recipients enrolled in the group health plan for items and services covered under the State Plan. Oregon pays for items and services provided to Medicaid recipients under the State Plan that are not covered in the group health plan. The group health plan will be treated as a third party resource as described in the State Plan for 42 CFR 433.138 and 433.139.

The following guidelines are used to determine cost effectiveness.

1. Determine if the group health plan is a basic/major medical policy or a health maintenance organization (HMO).
2. Determine the premium amount to be paid, converting any premiums that are not monthly, to a monthly amount.
3. Determine the number of Medicaid individuals to be covered.
4. Determine the average premium cost per Medicaid individual.
5. Determine the average monthly Medicaid cost savings for Medicaid persons who will be covered by the basic/major medical coverage or HMO coverage using the Medicaid Savings Chart.

The Medicaid Savings Chart is updated yearly. It is based on the MMIS WMMS757R-A report which is an analysis of the costs for Medicaid recipients with third party resources versus those Medicaid recipients without third party resources. The Medicaid Savings Chart is divided into categories of assistance, as follows:

- a. Old Age Assistance
 - b. Aid to Dependent Children
 - c. Aid to the Blind
 - d. Aid to the Disabled
 - e. Foster Care
6. The Medicaid agency will pay the premium amount if the premium cost per Medicaid individual is equal to or less than the corresponding amount shown on the Medicaid Savings Chart.

The cost effectiveness of the premium payment will be reevaluated at each redetermination.

TN No. 92-3

Supersedes

Approval Date 4/8/92

Effective Date 1/1/92

TN No.

Re "Other provider(s) reimbursed on a prepaid capitation basis", this is restricted to organizations that received grants under the Public Health Services Act in the Fiscal Year ending June 30, 1976.

Per 42 CFR 431.502: "Health maintenance organization (HMO)" means an entity determined by the Assistant Secretary for Health (Public Health Service) to meet the following requirements:

- (1) It provides to its Medicaid eligible enrollees as the "basic health services" required under sec. 1301 (b) and (c) of the Public Health Service Act--
 - (i) Inpatient hospital services;
 - (ii) Outpatient services;
 - (iii) Laboratory and X-ray services;
 - (iv) Family planning services and supplies;
 - (v) Physician services; and
 - (vi) Home health services for individuals entitled to those services under the Medicaid state plan.
- (2) It provides the services listed in paragraph (a) in the manner prescribed in sec. 1301(b) of the Public Health Service Act.
- (3) It is organized and operated in the manner prescribed in sec. 1301(c) of the Public Health Service Act.

Per 42 CFR 431.597(b): Non-availability of FFP: The limitation under paragraph (a) of this section does not apply to HMOs or health insuring organizations meeting the criteria of sec. 1903(m)(2)(B)(i), (ii) of the Act. These organizations generally include those that received grants under the Public Health Service Act in the fiscal year ending June 30, 1976, certain rural primary health care entities, and certain entities that operated on a prepaid risk basis before 1970.

Revision: HCFA-PM-92-4
AUGUST 1992

(HSQB)

Attachment 4.30
Page 1

State/Territory: OREGON

Citation

Sanctions for Psychiatric Hospitals

1902(y)(1),
1902(y)(2)(A),
1902(y)(3)
participation when the hospital's deficiencies immediately
jeopardize the health and safety of its patients or do not
immediately jeopardize the health and safety of its patients.

(a) The State assures that the requirements of section
1902(y)(1), section 1902(y)(2)(A), and section and Section
1902(y)(3) of the Act aremet concerning sanctions for
psychiatric hospitals that do not meet the requirements of
(P.L. 101-508,
Section 4755(a)(2)
of the Act

1902(y)(1)(A) of the Act (b) The State terminates the hospital's participation under the State plan
when the State determines that the hospital does not meet the
requirements for a psychiatric hospital and further finds that
the hospital's deficiencies immediately
jeopardize the health and safety of its patients.

1902(y)(1)(B) of the Act (c) When the State determines that the hospital does not meet the requirements for
a psychiatric hospital and further finds that the hospital's deficiencies do
not immediately jeopardize the health and safety of its patients, the
State may:

1. terminate the hospital's participation under the State plan; or
2. provide that no payment will be made under the State plan with
respect to any individual admitted to such hospital after the
effective date of the finding; or
3. terminate the hospital's participation under the State plan and
provide that no payment will be made under the State plan with
respect to any individual admitted to such hospital after the
effective date of the finding.

1902(y)(2)(A) of the Act (d) When the psychiatric hospital described in (c) above has not complied with the
requirements for a psychiatric hospital within 3 months after the date
the hospital is found to be out of compliance with such requirements,
the State shall provide that no payment will be made under the State
plan with respect to any individual admitted to such hospital after the
end of such 3-month period.

State/Territory: OREGON

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 428.726

P&I

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to impositions of temporary management:
- (c) The State's contracts with MCOs provide that payments provided for under the contract will be` denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).
- Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

INCOME AND ELIGIBILITY VERIFICATION SYSTEM

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged on a quarterly basis with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

Transmittal #87-22
ATTACHMENT 4.33-A
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oregon

**METHODS FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS**

In Oregon, the lack of a home address is not a deterrent to receiving Medicaid. Medicaid eligibility cards may be sent to anyplace the person chooses, i.e., post office box, general delivery, public shelter, etc. or the person may pick up the card at his/her local branch office.

TN No. 87-22

Supersedes

TN No.

Approval Date 7/13/87

Effective Date 4/1/87

HCFA ID: 108OP/0020P

Revision: HCFA-PM-91-9 (MB)
October 1991

Transmittal #93-1
ATTACHMENT 4.34-A
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

**REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR
MEDICAL ASSISTANCE**

The following is a written description of the law of the State (whether statutory or as organized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

TN No. 93-01
Supersedes
TN No. _____

Approval Date 2-16-93 Effective Date 1-1-93
HCFA ID: 7982E

**CHAPTER 761
AN ACT**

Transmittal #93-1
Attachment 4.34-A, Page 2

Relating to health care; and prescribing an effective date.

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

SECTION 1. As used in sections 1 to 4 of this 1991 Act:

(1) "Health care organization" means a home health agency, hospice program, hospital, long term care facility or health maintenance organization.

(2) "Health maintenance organization" has that meaning given in ORS 750.005, except that "health maintenance organization" includes only those organizations that participate in the federal Medicare or Medicaid programs.

(3) "Home health agency" has that meaning given in ORS 443.005.

(4) "Hospice program" has that meaning given in ORS 443.850.

(5) "Hospital" has that meaning given in ORS 442.015(13), except that "hospital" does not include a special inpatient care facility.

(6) "Long term care facility" has that meaning given in ORS 442.015(13) except that "long term care facility" does not include an intermediate care facility for individuals with mental retardation.

SECTION 2. Subject to the provisions of sections 3 and 4 of this 1991 Act, all health care organizations shall maintain written policies and procedures, applicable to all capable individuals 18 years of age or older who are receiving health care by or through the health care organization, that provide for:

(1) Delivering to those individuals the following information and materials, in written form, without recommendation:

(a) Information on the rights of the individual under Oregon law to make health care decisions including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care;

(b) Information on the policies of the health care organization with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;

(c) A copy of the directive form set forth in ORS 127.610 and a copy of the power of attorney for health care form set forth in ORS 127.530, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and

(d) The name of a person who can provide additional information concerning the forms for directives and powers of attorney for health care.

(2) Documenting in a prominent place in the individual's medical record whether the individual has disputed a directive or a power of attorney for health care.

(3) Insuring compliance by the health care organization with Oregon law relating to directives and powers of attorney for health care.

(4) Educating the staff and the community on issues relating to directives and powers of attorney for health care.

SECTION 3. The written information described in section 2(1) of this 1991 Act shall be provided

(1) By hospitals, not later than five days after an individual is admitted as an inpatient, but in any event before discharge;

(2) By long term care facilities, not later than five days after an individual is admitted as a resident, but in any event before discharge;

(3) By a home health agency or a hospice program, not later than 15 days after the initial provision of care by the agency or program but in any event before ceasing to provide care; and

(4) By a health maintenance organization, not later than the time allowed under federal law.

SECTION 4. (1) The requirements of sections 1 to 4 of this 1991 Act are in addition to any requirements that may be imposed under federal law, but this

1991 Act shall be interpreted in a fashion consistent with the Patient Self-Determination Act, enacted by sections 4206 and 4751 of Public Law 101-508. Nothing in this 1991 Act requires any health care organization, or any employee or agent of a health care organization to act in a manner inconsistent with federal law or contrary to individual religious or philosophical beliefs.

(2) No health care organization shall be subject to criminal prosecution or civil liability for failure to comply with this 1991 Act.

SECTION 5. Sections 1 to 4 of this Act are added to and made a part of ORS 127.505 to 127.583

SECTION 6. If Senate Bill 494 becomes law section 5 of this Act is repealed and section 7 of this Act is enacted in lieu thereof.

SECTION 7. Sections 1 to 4 of this 1991 Act are added to and made a part of sections 1 to 21,

Oregon Laws 1991 (Enrolled Senate Bill 494).

SECTION 8. This Act takes effect on December 1, 1991.

SECTION 9. Sections 1 to 4 of this Act are repealed December 1, 1993.

Approved by the Governor August 5, 1991
Filed in the office of Secretary of State August 5, 1991

SECTIONS 1-4 will follow ORS 127-650 as a "Note" entitled "Obligations of Health Care Organizations". This is based on Section 8 and 9 of this act.

**TN# 93-1 Approved 2/16/93
Supersedes TN# --- Effective 1/1/93**

POWERS OF ATTORNEY; DIRECTIVE TO PHYSICIANS 127.530

127.530 Form of power of attorney. A written power of attorney for health care shall provide no other authority than the authority to make health care decisions on behalf of the principal and shall be in the following form:

principal's attending physician. Witnessed
By:
(Signature of Witness/Date) (Printed Name of Witness)
(Signature of Witness/Date) (Printed Name of Witness)

POWER OF ATTORNEY FOR HEALTH CARE

ACCEPTANCE OF APPOINTMENT POWER OF ATTORNEY

I appoint _____, whose address is _____, and whose telephone number is _____, as my attorney-in-fact for health care decisions. I appoint _____, whose address is _____, and whose telephone number is _____, as my alternative attorney-in-fact for health care decisions. I authorize my attorney-in-fact appointed by this document to make health care decisions for me when I am incapable of making my own health care decisions. I have read the warning below and understand the consequences of appointing a power of attorney for health care.

I accept this appointment and agree to serve as attorney-in-fact for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner, and that I have a duty to inform the principal's attending physician promptly upon any revocation.

I direct that my attorney-in-fact comply with the following instructions or limitations: _____

(Signature of Attorney-in-fact/Date)
(Printed name)

In addition, I direct that my attorney-in-fact have authority to make decisions regarding the following.

(Signature of Alternate Attorney-in-fact/Date)
(Printed name)

_____ Withholding or withdrawal of life-sustaining procedures with the understanding that death may result.

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

_____ Withholding or withdrawal of artificially-administered hydration or nutrition or both with the understanding that dehydration, malnutrition and death may result.

This is an important legal document. It creates a power of attorney for health care. Before signing this document, you should know these important facts.

(Signature of person making appointment/Date)

This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations, specifications or statement of your desires that you include in this document.

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is the person appointed as attorney-in-fact by this document or the

For this document to be effective, your attorney-in-fact must accept the appointment in writing.

The person you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in a manner consistent with what the person in good faith believes to be in your best interest. The person you designate in this document does, however, have the right to withdraw from this duty at any time.

DIRECTIVE- TO PHYSICIANS 127.610

127.610 Execution and revocation of directive; form; witness qualifications and responsibility. (1) An individual of sound mind and 18 years of age or older may at any time execute or re-execute a directive directing the withholding or withdrawal of life-sustaining procedures should the declarant become a qualified patient. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS
Directive made this _____ day of _____ (month, year). I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, one of whom is the attending physician, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I understand that full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____
City, County and State of Residence _____
I hereby witness this directive and attest that:

(1) I personally know the Declarant and believe the Declarant to be of sound mind.

(2) To the best of my knowledge, at the time of the execution of this directive, I:

(a) Am not related to the Declarant by blood or marriage,

(b) Do not have any claim on the estate of the Declarant,

(c) Am not entitled to any portion of the Declarant's estate by any will or by operation of law, and

(d) Am not a physician attending the Declarant, a person employed by a physician attending the Declarant or a person employed by a health facility in which the Declarant is a patient.

(1) I understand that if I have not witnessed this directive in good faith I may be responsible for any damages that arise out of giving this directive its intended effect.

Witness
Witness

(2) A directive made pursuant to subsection (1) of this section is only valid if signed by the declarant in the presence of two attesting witnesses who, at the time the directive is executed, are not:

(a) Related to the declarant by blood or marriage;

(b) Entitled to any portion of the estate of the declarant upon the decease thereof under any will or codicil of the declarant or by operation of law at the time of the execution of the directive;

(c) The attending physician or an employee of the attending physician or of a health facility in which the declarant is a patient; or

(d) Persons who at any time of the execution of the directive have a claim against any portion of the estate of the declarant upon the declarant's decease.

(3) One of the witnesses, if the declarant is a patient in a long term care facility at the time the directive is executed, shall be an individual designated by the Department of Human Resources for the purpose of determining that the declarant is not so insulated from the voluntary decision-making role that the declarant is not capable of willfully and voluntarily executing a directive.

(4) A witness who does not attest a directive in good faith shall be liable for any damages that arise from giving effect to an invalid directive.

(5) A directive made pursuant to ORS 127.605 to 127.650 and 97.990(5) to (7) may be revoked at any time by the declarant without regard to mental state or competency by any of the following methods:

(a) By being burned, torn, canceled, obliterated or otherwise destroyed by the declarant or by some person in the declarant's presence and by direction of the declarant.

(b) By written revocation of the declarant expressing intent to revoke, signed and dated by the declarant.

(c) By a verbal expression by the declarant of intent to revoke the directive.

(6) Unless revoked, a directive shall be effective from the date of execution. If the declarant has executed more than one directive, the last directive to be executed shall control. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders the declarant able to communicate with the attending physician. [Formerly 97.055]

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS IN OREGON

DO I HAVE TO DO WHATEVER MY DOCTOR RECOMMENDS? No. You have a right to accept or refuse any proposed medical tests or treatment.

HOW WILL I KNOW HOW TO DECIDE? Your doctor will tell you what treatment or testing he or she recommends. Your doctor will then ask if you want to know more. If you do, your doctor will tell you about the treatment or test, the available alternatives and the material risks. When you have enough information, you decide whether to have the test or treatment.

HOW CAN I PLAN AHEAD FOR A TIME WHEN I MAY BE UNABLE TO MAKE DECISIONS? Oregon has only two official forms you can sign to cover future situations where you are unable to decide. A Directive to Physician is a legal statement that you do NOT want artificial life support which would only postpone your death when you are terminally ill. A Power of Attorney for Health Care lets you designate someone you trust, your representative, to make your health care decisions for you when you can't do so yourself. It allows your representative to give most directions you could have given. Your representative cannot act for you unless you become unable to make your own decisions.

HOW DO THESE HEALTH CARE PLANNING FORMS TAKE EFFECT? If you are an adult able to make your own decisions, you can sign either or both of these forms. You do not have to fill out and sign either form if you don't want to. However, if you do, your doctor must follow it or allow you to be transferred to a doctor who will.

The forms will not affect your insurance.

HOW DO I APPOINT SOMEONE ELSE TO ACT FOR ME? By using a "Power of Attorney for Health Care" form, you may select another adult as your health care representative. You may also appoint an alternate, if you wish. The representative and any alternate must sign the form agreeing to serve. You must also decide what authority you want to give those persons. Your representative is not obligated to pay your medical bills.

HOW DO I OBTAIN AND SIGN MY WRITTEN HEALTH CARE DOCUMENTS? Health care facilities and some stationery stores have the official forms. In Oregon, the only reliable way to be sure your wishes are followed is to use the official forms. Do not change them except by filling in the blanks. Don't add anything about money or property. Each must be signed by you and two witnesses who must satisfy special requirements. Read and follow the directions. Send a copy to your doctor and to anyone you choose as a representative. Keep the original where it can be found.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Transmittal #95-15
Attachment 4.35-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A - OAR 411-73-030

TN No. 95-15

Supersedes

TN No. 90-16

Approval Date:

2/13/96

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JUNE 1995

Transmittal #95-15
Attachment 4.35-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-110

TN No. 95-15

Supersedes

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TN No.

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JUNE 1995

Transmittal #95-15
Attachment 4.35-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-100

Alternative Remedy

(Describe this criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-15

Supersedes

TN No.

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JUNE 1995

Transmittal #95-15
Attachment 4.35-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at S1919(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-080

TN No. 95-15

Supersedes

TN No.

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Effective Date: 10/1/95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Transmittal #95-15
Attachment 4.35-E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-090

TN No. 95-15

Supersedes

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TN No.

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Transmittal #95-15
Attachment 4.35-F

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-070

TN No. 95-15

Supersedes

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TN No.

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JUNE 1995

Transmittal #95-15
Attachment 4.35-G

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-110

TN No. 95-15

Supersedes

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Effective Date: 10/1/95

TN No.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Transmittal #95-15
Attachment 4.35-H

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

No additional remedies under federal requirements.

TN No. 95-15

Supersedes

Approval Date: 2/13/96

Effective Date: 10/1/95

TN No.

Revision: HCFA-PM-91-10 (BPD)

Transmittal #92-8
Attachment 4.38
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

1. Full name of nursing assistant
2. Information to identify each individual, including date of birth
3. Previous three places of employment (as a CNA)
4. Advanced training completed (medication aide, home health aide, psychiatric aide)
5. Date individual passed competency evaluation program or was deemed eligible
6. Information relating to findings of abuse, neglect or misappropriation of property
 - a. Documentation of investigation
 - b. Date of hearing, if any, and its outcome
 - c. Individual's statement refuting allegation.

TN No. 92-8

Supersedes

TN No.

Approval Date 5/14/92

Effective Date 1/1/92

HCFA ID:

Revision: HCFA-PM-91-10 (BPD)

Transmittal #92-8
Attachment 4.38A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

1. Full name of nursing assistant
2. Social Security Number
3. Information to identify each individual, including date of birth
4. Advanced-training completed (medication aide, home health aide, psychiatric aide)
5. Previous three places of employment (as a CNA)
6. Date individual passed competency evaluation program or was deemed eligible
7. Information relating to findings of abuse, neglect or misappropriation of property
 - a. Documentation of investigation
 - b. Date of hearing, if any, and its outcome
 - c. Individual's statement refuting allegation.

TN No. 92-8

Supersedes

TN No.

Approval Date 5/14/92

Effective Date 1/1/92

HCFA ID:

Definition of Specialized Services

For Persons With Mental Retardation/Developmental Disabilities (MR/DD):

Specialized services in nursing facilities (NFs) are services paid solely by State of Oregon funds which increase access to, and participation in, community events and activities, including community-based employment and alternatives to employment (work activity centers, senior centers, etc.). If an individual's physical condition does not permit participation in community-based services, the State will provide specialized services in the NF.

For Persons With Mental Illness (MI):

Specialized services are generally not offered in NFs, but rather in psychiatric units of JCAHO-certified hospitals. Each individual's plan of care identifies specific therapies and activities to be delivered on a continuous basis (24 hour day) to treat acute episodes of serious mental illness. Interdisciplinary teams of qualified mental health professionals (each including a physician) develop, implement and supervise the individual's services. The goal of the individual plan of care is to return the individual to his or her maximal level of functioning so that they can be maintained by less intensive services.

TN # 94-19
SUPERSEDES
TN # 93-12

DATE APPROVED 3/13/95
EFFECTIVE DATE 10/1/94

Categorical Determinations

I. Nursing Facility Services Needed:

For persons with either Mental Retardation/Developmental Disabilities (MR/DD) or Mental Illness (MI), the State of Oregon may make an advance group determination that nursing facility (NF) services are needed for any of the following situations:

Convalescent Care:

The individuals currently in an acute care hospital recovering from an illness or surgery, the likely stay in the NF will not exceed 30 days (60 days if MR/DD), and resources necessary to meet the individual's post-NF needs are arranged or are being developed;

Terminal Illness:

The applicant's attending physician has certified, prior to NF placement, an explicit terminal prognosis with a life expectancy of less than 6 months;

Severe Physical Illness:

The individual has a severe chronic medical condition or illness that precludes participation in, or benefit from, specialized services (examples: coma, ventilator dependence, functioning at a brain stem level, chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure);

Respite Care (DD only):

The individual requires NF services for a maximum stay of 30 days per year as a respite for his or her in-home caregivers, and resources necessary to meet the individual's post-NF needs are developed; or

Emergency Situations (DD only):

The individual is granted provisional admission, pending further assessment, in emergency situations requiring protective services. The length of such NF placement will not exceed 7 days.

Regardless of the original categorical determination status of each individual admitted to a NF, the State of Oregon will continue to monitor the need of every NF resident for a Level II assessment through the Annual Resident Review and other processes.

TN # 94-19
SUPERSEDES
TN # 93 -12

DATE APPROVED 3/13/95
EFFECTIVE DATE 10/1/94

Categorical Determinations (continued)

II. Specialized Services Not Needed:

For persons with Mental Retardation/Developmental Disabilities (MR/DD), the State of Oregon may make an advance group determination that specialized services are not needed for any of the following situations:

Dementia In Combination With Mental Retardation:

The individual has a primary diagnosis of dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM), in combination with mental retardation or a related condition;

Delirium:

The individual has a primary DSM diagnosis of delirium and the State cannot make an accurate evaluation of the need for specialized services until the delirium clears;

Emergency Situations:

The individual is granted provisional admission, pending further assessment, in emergency situations requiring protective services. Such placement in a NF will not exceed 7 days; or

Respite Care:

The individual will not be likely to experience a developmental or physical decline in the absence of specialized services during a respite stay (an individual's respite care schedule should remain as close as possible to the home environment's schedule).

PASARD12.04

TN # 94-19
SUPERSEDES
TN # ____

DATE APPROVED 3/13/95
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Revision: HCFA-PM-92- 3 (HSQB)
APRIL 1992

Transmittal #92-16
Attachment 4.40-A
Page I
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The state has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

State-wide joint trainings are offered at least annually in cooperation with the long-term care provider associations. Topics involve current regulations, policies and procedures and updates. In addition, group interviews and special exit conferences are conducted with residents and their representatives at each annual re-certification survey for the purpose of providing information about current regulations and compliance issues.

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TN No. ---

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Transmittal #92-16
Attachment 4.40-B
Page I
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

**Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property**

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

State law and policy/procedure specify nursing facility abuse complaints must be investigated within two hours of receipt. This function is carried out by specially trained local staff in conjunction with a Registered Nurse at the State level. Investigation reports are reviewed at the State level and sanctions are levied as indicated.

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Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

All scheduling information is strictly confidential. Life safety code survey staff are not notified of the conduct of the health survey until after the entrance has occurred. Schedules are developed within a 120day window in order to avoid giving notice.

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TN No. ---

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Attachment 4.40-D
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Quarterly trainings are held for the purpose of informing and educating survey staff in survey methods in order to reduce inconsistency. Regional office staff participate in these trainings in order to clarify regulations and policies and procedures and to interpret HCFA Central office information.

Other programs regularly incorporated into the quarterly trainings are presentations by specialty survey staff, such as dieticians and social workers; individual and group exercises to measure application of scope and frequency to citations; and exercises to measure consistency in deficiency identification by individual surveyors and survey teams.

As much as possible, survey teams are drawn from a pool for each assignment, allowing for interchange among surveyors.

Bi-weekly staff meetings include instruction on and discussion of survey consistency issues with all staff.

Additional processes to reduce inconsistency include supervisory "round table review" of survey reports together with the survey teams, and a supervisory audit procedure to review reports for consistency between offices.

Quality improvement monitoring is ongoing.

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APRIL 1992

Transmittal #92-16
Attachment 4.40-E
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

A complement of staff is maintained in order to investigate complaints. Referrals are made to the State level for investigation of complaints of facility-wide substandard care or patterns of non-compliance.

Follow-up is conducted to assure correction of deficiencies identified through the re-certification survey and a mechanism exists to provide for on-site monitoring of facilities whose ability to maintain compliance is questionable.

TN No. 92-16

Supersedes

TN No. ---

Approval Date 8/12/92

Effective Date 4/1/92

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oregon

Employee Education Regarding False Claims Recovery
Methodology of Compliance Oversight

State will oversee compliance through existing and other methodologies found to comply with requirements of Section 6032 of the Deficit Reduction Act 2005. Methods include but are not limited to contract and intergovernmental agreement approval and management; systematic quality assurance/quality improvement reviews; provider/entity enrollment procedures; provider/entity education and training; auditing. The State began to disseminate information regarding the requirements for compliance across all affected providers/entities January 9, 2007 and will follow with additional guidance through regular communication and training channels. The State will provide to all affected providers/entities basic information outlining what is necessary for compliance and material that may be used for compliance purposes. The State will continue its use of effective mechanisms available to prevent, detect and report fraud, waste and abuse in federal health care programs.

In CY 2007 affected providers/entities will be identified and provided with the information described above. Thereafter and on an annual basis, the State will obtain information on additional affected providers/entities and follow the process described above. Non MCO contracts and FFS providers/entities will be notified of the obligation to comply with state and federal regulations, contracts or agreements will be amended on the next renewal, and that the Department's oversight and compliance will begin upon receipt of notification or by September 30, 2007 whichever is first. The Department will audit provider/entities for compliance during the audit unit's regular schedule.

Managed Care contracts were amended for the term that began January 1, 2007 in order to require compliance with section 6032 referenced above. The Department reviews the MCO contractors on an annual basis for contract compliance which will also include compliance with this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: OREGON

STANDARDS OF PERSONNEL ADMINISTRATION

1. See ORS Chapter 240 as amended in 1973.
2. See Personnel Rules and Merit System Laws as amended August, 1972.
3. See Rules of the Public Employee Relations Board as amended February, 1974

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

1. PURPOSE

This plan outlines procedures and policies by which DHHS funded Agencies comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended and Age Discrimination Act of 1975.

II. POLICY

Under the provisions of Title VI, Civil Rights Act of 1964 (42 USC 2000 d. et. seq.) with 45 CFR Part 80, Section 504 of the Rehabilitation Act of 1973 (29 USC 706) with 45 CFR Part 84 (Sub-parts A,b,C, and F), and the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) with 45 CFR Part 90 no individual shall, on the grounds of race, color, national origin, or persons with disabilities, or age shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under federally assisted programs and activities for which the Oregon Health Authority has responsibility. This same policy of non-discrimination is equally applicable to all OHA contractors, grantees, agents, and providers of services funded in whole or in part with Federal Funds from the Department of Health and Human Services.

A. This policy encompasses in scope and application the civil rights of employee, clients, recipients, applicants, and beneficiaries of DHHS-funded programs operated by or in behalf of the OHA.

B. Title VI of the Civil Rights Act prohibits acts of discrimination based on race, color, and national origin.

C. Section 504 of the Rehabilitation Act prohibits discrimination based on handicap. The term "Persons with disabilities" includes such diseases or conditions as: speech, hearing, visual and orthopedic impairments, cerebral palsy, epilepsy, muscular dystrophy, HIV, multiple sclerosis, cancer, diabetes, heart disease, mental retardation, emotional illness; and specific learning disabilities such as brain dysfunction, and developmental aphasia. Alcohol and drug addicts are also considered individuals with disabilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

D. The age discrimination act prohibits discrimination based on age in programs or activities.

The Age Discrimination Act prohibits discrimination based on age in programs of activities. The Act and the implementing regulations contain certain exceptions to the broad provision against discrimination. A program is permitted to use age distinctions in programs which have been "established under any law" such as the programs authorized by the Older Americans Act.

A facility is also permitted to take action based on age distinctions, if the action reasonably takes in to account ages as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor if all the four conditions are met. These factors are referred to as the "Four Part Test".

1. Age is used as a measure or approximation of one of more other characteristics; and
2. The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
3. the other characteristic(s) can be reasonably measure or approximated by the use of age; and
4. The other characteristic(s) are impractical to measure directly on an individual basis.

III. ASSIGNMENT OF RESPONSIBILITY FOR IMPLEMENTATION OF TITLE VI AND SECTION 504, AND THE AGE DISCRIMINATION ACT.

Director

The OHA Director, shall designate an Individual(s) responsible for overseeing Title VI and 504 and the Age Discrimination Act.

OHA Director, managers and supervisors all have responsibilities to carry out Title VI, 504 and Age Discrimination compliance activities.

TN No. 11-01

Approval Date: 4/4/11

Effective Date: 6/30/11

Supersedes TN No. 89-21

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

IV. TITLE VI AND SECTION 504 ORIENTATION AND/OR TRAINING

The OHA Director, managers and supervisors convey to all staff their responsibilities under Title VI, Section 504 and the Age Discrimination Act. This is accomplished by providing, as part of a new employee's orientation and periodic retaining of permanent employee, information regarding the obligation, intent, and meaning of Title VI, Section 504 and the Age Discrimination Act.

Staff who have contact with program beneficiaries are aware of the ethnic, cultural, and language differences that may have important impact on the delivery of services to minority persons; and the needs of the handicapped, including any barriers to their full participation in the agency's program; and actions that result in denying or limiting services or otherwise discrimination on the basis of age. This is accomplished in a variety of ways, including training sessions and distribution of written information.

V. TITLE VI, AND SECTION 504 AND AGE DISCRIMINATION ACT COMPLIANCE BY OTHER PARTICIPANTS

The OHA recognizes that its obligations for compliance extend to its service vendors, service contractors, and other providers of services, financial aid, and other covered benefits under the agency's DHHS-funded programs. The OHA assures that such participants in its DHHS-funded programs comply with Title VI, Section 504, the Age Discrimination Act and their respective Regulations.*

VI. TITLE VI, AND SECTION 504 AND AGE DISCRIMINATION ACT COMPLIANCE POLICY AND PROCEDURE.

OHA has an established client complaint policy and procedure.*

*Details for individual policies can be found in the OHA office of Multicultural Health and Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

VII. RECRUITMENT AND EMPLOYMENT PRACTICES (TITLE VI AND SECTION 504)

Regarding Title VI, where the primary objective of the federal financial assistance to an OHA Division is to provide employment, the responsible agency has developed policies and procedures to assure that all recruitment and employment practices for positions provided with such federal financial assistance do not discriminate on the basis of race, color, or national origin.

Even where the primary objective of the federal financial assistance is not to provide employment, the agency has policies and procedures to help assure that its employment practices do not have the effect of causing discrimination in the delivery of services and benefits under its programs. -

Regarding 504, the agency has policies and procedures to assure that no qualified "persons with disabilities" shall, on the basis of handicap, be subjected to discrimination in employment regardless of the primary objective of the federal financial assistance.

The agency has policies to assure that training and educational leave are provided to its employee in a non-discriminatory manner.*

VIII. PLANNING, ADVISORY, AND POLICY BOARDS

OHA assures that the opportunity to participate as members of planning, advisory, and policy boards, appointed or recommended by agents of the agency, which are integral parts of its program, is available to all persons in non-discriminatory manner.

IX. CONTINUING COMPLIANCE

OHA has procedures for monitoring all aspects of its operation to assure that no policy or practice is, or has the effect of, discriminating against beneficiaries or other participants on the basis of race, color, national origin, or handicap, or age. Procedures have been established to review all new and existing policies to determine compliance of such policies with title VI, and Section 504, and the Age Discrimination Act.*

*Details for individual policies can be found in the OHA office of Multicultural Health and Services,

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

X. PROGRAM ACCESSIBILITY

OHA assures that no qualified person with disabilities shall be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any of its programs or those of its vendors, because the facilities are inaccessible, or unusable by persons with disabilities.

The Authority shall set forth procedures for assuring that any facility or part of any facility which is constructed or altered by, on behalf of, or for their use, is made readily accessible to and usable by persons with disabilities.

OHA assures that no person, on the basis of age, be denied the benefits of, be excluded from participation in, or be subject to discrimination. Any Policies which omit programs or activities on the basis of age must describe how the policy or practice takes into account age as a factor necessary to the normal operation or the achievement of a statutory objective of the program or activity. The description should include all the factors in the "Four Part Test".

XI. CORRECTIVE REQUIREMENTS

The agency can take corrective action to overcome the effects of prior discrimination in instances where the agency, or its service vendors have previously discriminated against clients on the grounds of race, color, national origin, religion, sex, handicap, or age.

Even in the absence of such prior discrimination, a agency may take corrective action to overcome the effects of conditions which resulted in limiting service participation by persons of a particular race, color, national origin, or handicap, or age.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

XII. COMPLIANCE RECORDS

The agency is responsible for collection and maintenance of racial/ethnic data which will show the extent to which minority persons are participating in all aspects of the agency's DHHS-funded programs; i.e., day care, clinics, hospitals, sheltered workshops, etc. The agency requires such data and information from vendors (see section on compliance by other participants).

Each agency shall make available to the Office for Civil Rights all data and information necessary to determine that agencies compliance with Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act; and its implementing Regulation, as well as the compliance status of its vendors. This information shall be reviewed by the OHA Director, prior to submission to the Office for Civil Rights.

STATE OF OREGON

Transmittal #78-17
Attachment 7.3A

The Governor has delegated authority for approval of plan material which does not have a fiscal impact nor represents a significant new or revised policy, to the Director of the Department of Human Resources.

TN# 78-17
Supersedes TN# ---

Date Approved 11/22/78
Effective Date 10/1/78

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0011- 1915(i)

Effective Date : 3/1/20

Approval Date: 4/24/20

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Temporary, time limited changes to 1915(i) Home and Community-Based Services Option

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon’s Medicaid state plan, as described below:

Oregon, with agreement from Oregon’s tribes, will provide notification and an expedited consultation process.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

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Less restrictive resource methodologies:

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Page

TN. 20-0011- 1915(i)

Effective Date : 3/1/20

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Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. _____ The agency uses a simplified paper application.
 - b. _____ The agency uses a simplified online application.
 - c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. _____ The agency suspends enrollment fees, premiums and similar charges for:
- a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

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Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (including service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirement found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found t 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

[Empty rectangular box]

Telehealth:

5. X The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

Allow needs-based eligibility criteria evaluations and re-evaluations to be completed by communication methods such as telehealth/telemedicine in lieu of face to face visits and in accordance with HIPAA, as directed by OHA.
Allow person-centered service plan(PSCP) development and completion by communication methods such as telehealth/telemedicine, in lieu of face to face visits and in accordance with HIPAA, as directed by OHA.
Allow Home-based Habilitation, HCBS Behavioral Habilitation, and Psychosocial Rehabilitation services to be provided via telehealth/telemedicine, in lieu of face to face visits and in accordance with HIPAA, as directed by OHA.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

[Empty rectangular box]

7. _____ Prior authorization for medications is expended by automatic renewal without clinical review, or time/quantity extensions.

[Empty rectangular box]

8. _____ The agency makes the following payment adjustments to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply

documentation to justify the additional fees.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

TN. 20-0011- 1915(i)

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E – Payments

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Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

a. Published fee schedules –

Effective date (enter date of change): 3/1/20

Location (list published location): _____

b. _____ Other:

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

a. _____ Payment increases are targeted based on the following criteria:

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

Up to the Medicare payments for equivalent services.

By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:

a. Are not otherwise paid under the Medicaid state plan;

b. Differ from payments for the same services when provided face to face;

c. Differ from current state plan provisions governing reimbursement for telehealth;

Telehealth will be used for : Case management-assessment, person-centered service

planning and monitoring; Habilitation; and Psychosocial rehabilitation. This will sunset on the last day of the public health emergency.

d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ____ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. ____ The individual’s total income

b. ____ 300 percent of the SSI federal benefit rate

c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1.above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Person-Centered Service Planning & Delivery

To comply with 42 CFR 441.725(b)(9), appropriate IQA staff may obtain the individual’s verbal approval

and document this approval in the case records as directed by OHA. The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Verbal consent is only used as authorization for providers to deliver services while awaiting receipt of the signed person-centered service plan (PCSP). Verbal consent does not substitute for electronic or hardcopy signatures on the PCSPs

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PCSPs that are expiring require a contact to the individual to verify with the individual or representative that the current assessment and services, including providers, remain acceptable and approvable for the upcoming year allowing for receipt of the signed form via the use of e-signatures that meet privacy and security requirements. Services may start while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include a date reflecting the ISP meeting date.

PCSP revisions will be updated within 60 days of service needs identified to mitigate harm or risk directly related to COVID-19 impacts, as directed by OHA, with individual approval obtained using the process described above.

Home and Community-Based Services in Inpatient Settings

Temporarily allow payment for the provision of Home-Based Habilitation, HCBS Behavioral Habilitation and Psychosocial Rehabilitation services to eligible individuals who are being served in an inpatient setting in order to enable direct care workers or other home and community-based providers to accompany individuals to any setting necessary.

(a) these services will be focused on providing personal, behavioral and communication supports not otherwise provided in an acute care hospital;

(b) the service will only be delivered in the alternate setting for up to 30 days;

(c) identified in an individual's person-centered service plan (or comparable plan of care);

(d) provided to meet needs of the individual that are not met through the provision of hospital services;

(e) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

(f) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information

collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

Transmittal # 20-0008

Attachment 3.1-K

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Temporary changes to the Community First Choice State Plan Option

The State Medicaid agency seeks to implement the policies and procedures for the provision of Community First Choice State Plan Option, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) for the period of the public health emergency. These policies and procedures are time limited to no later than the termination of the national public health emergency, including any extensions.

The following are temporary measures related to Oregon's response to the COVID-19 outbreak. The state will work with CMS to revert back to pre-emergency policies as circumstances allow. Oregon requests an effective date of March 1, 2020 with a termination date to be determined by the end of the emergency declaration, including any potential extensions.

I: Eligibility

The following requirement is temporarily waived, as directed by DHS.

- Allow level of care evaluations or re-evaluations to be completed by communication methods in lieu of face to face, such as telehealth, as directed by DHS. Suspend the requirement for annual re-evaluations until the Emergency Declaration is repealed by the President unless there is a change of condition requiring additional services for the individual.

IV. Service Package:

- The following is added to the definition of Attendant Care Services:

The state may determine when it is appropriate for attendant care services to be delivered by communication methods in lieu of face to face, such as telehealth for ODDS-eligible individuals.

- Allow two meals per day to be provided through the home delivered meals program.

TN No. 20-0008

Approval Date:

Effective Date: 3/1/20

Supersedes TN No. NEW

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Temporary changes to the Community First Choice State Plan Option

V. Qualification of Providers of CFC Services

The following sections are added:

- Homecare Workers and Personal Support Workers (Independent Providers): Homecare Workers and Personal Support Workers may be permitted to begin working unsupervised when a positive preliminary fitness determination (verified that they are not on the federal exclusionary list) is made, prior to a final fitness determination, as directed by DHS.
- DHS licensed and certified providers of 1915(k) services, as directed by DHS, may implement the following workforce shortage mitigation strategy:

Staff providing attendant care for these providers may be permitted to begin working unsupervised when a positive preliminary fitness determination is made (verified that they are not on the federal

exclusionary list), prior to a final fitness determination. Unless exempt under state law, staff must complete continuing education credits every 12 months, but may continue providing services if continuing education requirements are not completed, as directed by DHS.

VI: Home and Community-Based Settings

- Temporarily revise state plan provisions to allow the provision of Community First Choice Personal Care services to a recipient in an acute care hospital as long as the services are identified in an individual’s personal plan of care, address needs that are not met through the provision of hospital services, are not duplicative of services the hospital is obligated to provide, and are designed to ensure smooth transitions between acute care settings and home and community-based settings, and preserve the individual’s functional abilities.

IX: Assessment and Service Plan:

- Case Managers and Assessors may complete all assessments, including the risk assessment, by communication methods such as telehealth, in lieu of face to face assessments

TN No. <u>20-0008</u>	Approval Date:	Effective Date: <u>3/1/20</u>
Supersedes TN No. <u>NEW</u>		Transmittal # 20-0008 Attachment 3.1-K Page 47

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Temporary changes to the Community First Choice State Plan Option

X. Person-Centered Service Plan Development Process

- Case Managers may complete the person-centered service planning process by communication methods such as telehealth, in lieu of face to face.
- Person-centered service plans/revisions may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly related to COVID-19 impacts.

TN No. <u>20-0008</u>	Approval Date:	Effective Date: <u>3/1/20</u>
Supersedes TN No. <u>NEW</u>		

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Temporary changes to 1915(j) for the Independent Choices Program

The State Medicaid agency seeks to implement the policies and procedures for the provision of Independent Choices Program, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) for the period of the public health emergency. These policies and procedures are time limited to no later than the termination of the national public health emergency, including any extensions.

The state will work with CMS to revert back to pre-emergency policies as circumstances allow. Oregon requests an effective date of March 1, 2020 with a termination date to be determined by the end of the emergency declaration, including any potential extensions.

vii. Participant Living Arrangement

- The state may waive the three consecutive months of tenancy as a condition of eligibility.

x. Service Plan

- Individuals that have responsibility to develop or manage service plans may provide other direct services to participants only if a provider is suddenly unavailable. If this occurs, the following will occur to avoid any possible conflict of interest:
 - Increased case management contact to occur with the participant and representative at least twice per month;
 - Any changes to the service plan such as a change in a provider or the number of hours worked must have the review of a case manager;
 - Any changes to the service plan that include a change in the care setting must have the review of a case manager;

The case manager may terminate the agreement if any conflict of interest becomes apparent. Alternatives must be provided if this were to occur.

xii. Risk Management

- The state may utilize the risk assessment and monitoring instrument by telehealth if:
 - The participant agrees to participate in this manner; and
 - An in-person evaluation is not considered necessary in order to properly assess or monitor.

TN 20-0009

Approval Date

Effective Date: 03/1/20

Supersedes TN NEW

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0010- General provisions

Effective Date : 3/1/20

Approval Date: 6/18/20

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Temporary, time limited changes until the end of the national public health emergency, including any extensions.
--

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon’s Medicaid state plan, as described below:

Please describe the modifications to the timeline. Tribal entities are informed of any urgent SPAs or waivers via our monthly Tribal Meetings and DTLL however instead of the 30, 60, 90 day time periods the agency requests expediated review due to the urgent nature of the SPA.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

4. X The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

3. X The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Page Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

Contracted Community Partner organizations will be designated as qualified entities to make presumptive eligibility determinations. Individuals are limited to 2 presumptive eligibility determinations within a 12 month period beginning with the effective date of coverage of the initial PE period. The MAGI populations the qualified entities can make determination for are: Parent or Other Caretaker Relative, MAGI Adult, MAGI Pregnant Woman, MAGI Child, Former Foster Care Youth Medical, Breast and Cervical Cancer Treatment Program.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

a. _____ The agency uses a simplified paper application.

b. _____ The agency uses a simplified online application.

c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. ____ The agency suspends enrollment fees, premiums and similar charges for:

a. ____ All beneficiaries

b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (including service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. X The agency makes the following adjustments to benefits currently covered in the state plan:

Effective March 1, 2020, for the purposes of testing to diagnose or detect SARS-CoV-2. Antibodies to SARS-CoV-2, or COVID-19, test conducted in non office settings such as parking lots are covered, exempting requirements in 42 CFR 440.30(b).

Coverage also includes laboratory processing of self-collected test systems that the FDA has authorized for home use, if available to diagnose or detect SARS-CoV-2. Antibodies to SARS-CoV-2, or COVID-19, even if those self-collected test would not otherwise meet requirements in 42 CFR 440.30(a) or (b), as long as the self-collection of the test is to avoid transmission of COVID-19.

3. X The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirement found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found t 1902(a)(23).

4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

OHA is Allowing DXC to exercise clinical judgment to waive day supply limits when appropriate to reduce exposure risk. Early refill allowed when appropriate for a 2-week reserve supply Consider client, stakeholder and agency messaging for mail order pharmacy

7. Prior authorization for medications is expended by automatic renewal without clinical review, or time/quantity extensions.

8. The agency makes the following payment adjustments to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

a. Published fee schedules –
Effective date (enter date of change): _____

Location (list published location): _____

b. Other:

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

a. Payment increases are targeted based on the following criteria:

b. Payments are increased through:

i. A supplemental payment or add-on within applicable upper payment limits:

ii. ____ An increase to rates as described below.

Rates are increased:

____ Uniformly by the following percentage: _____

____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

____ Up to the Medicare payments for equivalent services.

____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. X For the duration of the emergency, the state authorizes payments for telehealth services that:

a. ____ Are not otherwise paid under the Medicaid state plan;

b. ____ Differ from payments for the same services when provided face to face;

c. X Differ from current state plan provisions governing reimbursement for telehealth;

Providers using POS 2 for telehealth will receive the non facility RVU rate regardless of the type of entity they are until the end of the public health emergency.

d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*4. Other payment changes:

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions. These temporary rate methods account for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) All Mental health and Substance Use Disorder residential treatment providers: Utilizing State Plan methods currently approved under Attachment 4.19-B, section 24.f which established Reserve Service Capacity payments to providers while the individual is hospitalized or absent from the congregate setting as authorized by the agency. OHA will reimburse providers during the emergency period for the costs of maintaining service capacity in light of reduced occupancy created from COVID-19 response. Providers reimbursement will be limited by average Medicaid occupancy in 2019. Reasons for reimbursement would include vacancies created as a result of reconfiguring bed space for physical distancing and lower referrals due to COVID-19 concerns. This would include all mental health residential for children and adults, and substance abuse residential for children and adults.

2) For Tribal 638 and Urban Indian Health programs utilizing PPS:

At the option of the health program, provide an enhanced PPS rate during the duration of the public health emergency. Each tribal 638/urban Indian health program's enhanced PPS rate will be calculated and updated monthly and retrospectively and will be determined by dividing total Medicaid FFS billing for services rendered during the analogous calendar month in 2019 by the total number of Medicaid patient encounters during the same month in 2020. This rate will be applicable retroactive to 3/1/2020.

For Indian Health Service /Tribal 638 programs utilizing the IHS/MOU rate:At the option of the health program, provide supplemental payments representing the difference between the IHS/MOU rate and the amount the provider would receive if this rate were calculated using the enhanced PPS methodology described above

3) Rates for nursing facilities, assisted living facilities, residential care facilities are increased by 10%. This includes all program sections under the current state plan that utilizes these facilities such as 1915(k), general programs, ABP. This also includes ODDS settings such as Adult Group Home (AGH) and Group Care Homes for Children (GCH).

4) OHA will offer interim stability payments to help providers continue in business during the public health emergency. Excluded providers under this paragraph are pharmacies, pharmacists, direct medical equipment providers, and any providers reimbursed under options 1,2,3,5 and 6 included in this temporary SPA. Eligible providers under paragraph must also have an active contract in good standing with OHA FFS as of March 1, 2020. Providers must attest to their continuing to provide Medicaid services.

Eligible providers must apply for interim payments, and the amount of payment to any applying provider will be determined by OHA. The payment amount will be the average monthly billing to OHA FFS in CY 2019, times the number of months claimed. The months claimed start with March 2020 and run through the month in which the application is filed, and in the case of subsequent applications will be offset by any previous months claimed. For any service month for which the provider has already received claims payment for services furnished in that month, the interim payment to be issued for that month will be reduced to account for the claims payment already made. Monthly interim payments will not be made in advance for future periods. Applications may be filed until the end of the Public Health Emergency. Interim payments are subject to reconciliation with final payments for which providers are eligible based on billed claims. Reconciliation will be completed by the end of the quarter following the end of the public health emergency. Any overpayments must be returned to CMS by the quarter after the reconciliation.

5) Newly created HCPCS code (U0001) and (U0002) Diagnostic Test Panel COVID-19, to be paid at 100% of Medicare with no AB 97 reduction.

6) Due to nurse providers getting sick or refusal to enter certain homes, or the possibility of nurses finding alternative work in higher paying health settings (hospitals), the universe of available nurses may be strained due to the COVID -19 crisis. To maintain the pool of private duty nursing providers for the medically fragile children receiving these services, OHA proposes a temporary increase in rates for independent LPNs and RNs, and agency LPNs to match the current rate paid for Agency RNs at \$62 per hour. This will allow agencies to recruit more LPNs and retain existing staff nurses for these services during the Public Health Emergency.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

- a. ____ The individual’s total income
- b. ____ 300 percent of the SSI federal benefit rate
- c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1.above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0013- 1915(i) #2

Effective Date : 3/1/20

Approval Date: 7/16/20

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon’s Medicaid state plan, as described below:

Oregon, with agreement from Oregon’s tribes, will notification and an expediated consultation process.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (including service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

[Empty box for optional benefits]

2. The agency makes the following adjustments to benefits currently covered in the state plan:

The additional provider types and qualifications are as follows:

Assisted Living Facility- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years);

Group Care Homes and State Operated Group Homes for Adults - Licensing or Certification requirements at OAR 411-325-0010 through 411-325-0480. DHS Central Office is responsible for verification of provider qualifications biennially;

Residential Care Facility- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years);

APD and ODD Adult Foster Care - Licensing requirements at OAR 411-050-0600 – 0690 OAR 309-040-0030 through 309-040-0330; and 411-360-0010 through 411-360-0310. Branch offices, DHS Central Office, and OHA/HSD are responsible for verification of provider qualifications upon initial license and annual renewal.

These four additional provider types will be providing Home-Based Habilitation and HCBS Behavioral Habilitation 1915(i) state plan services.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirement found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found t 1902(a)(23).

4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Section E – Payments

Other:

4. X Other payment changes:

Payments for services provided in the following DHS-licensed/certified settings will be made using the approved rate methodology for services provided in these settings under the 1915(k) Community First State Plan option as described below:

Assisted Living Facility- Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individuals assessed needs. An independent and Qualified agent conducts the need assessment using the LOCUS and LSI assessment tools for the individual enrolled in 1915(i) are the LOCUS and LSI assessments, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:

Level 1 -- All individuals qualify for Level 1 or greater.

Level 2 -- Individual requires assistance in cognition/behavior AND elimination or mobility or eating.

Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

Level 5 -- Individual is full assist in three to six activities of daily living OR full assist in cognition/behavior AND one or two other activities of daily living.

Group Care Homes for Adults- Each individual's support needs be assessed using a functional needs assessment annually, when an individual requests it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual person-centered planning meetings, and when there are changes to the person's condition:

- The functional needs assessment collects information about the person's support needs. This information is used to match the individual with one of several levels of expected support need. For individuals enrolled in 1915(i), the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment.
- A funding tier is assigned. Each funding tier corresponds to the functional needs assessment derived expected support levels.
- Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjust by the size of setting (licensed capacity) in which they reside.

State Operated Group Care Homes for Adults- Each individual's support needs are assessed using a

functional needs assessment. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual eligibility redeterminations, annual person- centered service plan meetings, and when there are changes to the person's condition. The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that DHS and OHA can assure that the total funding does not exceed the cost of operating the site.

Residential Care Facility Regular- Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries.

Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the APD functional needs assessment to determine the base rate and any potential add-ons. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if:

(A) The individual is full assist in mobility or eating or elimination;

(B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or

(C) The individual's medical treatments, as documented in the needs assessment, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

Residential Care Facility Contract- Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries.

Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:

Supplemented Program Contract (as referred to in 1915(k) state plan): Allows an enhanced rate for additional services in excess of the published rate schedule to providers in return for additional services delivered to target populations.

Residential Care Facility Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of individuals whose service needs exceed the service needs encompassed in the base payment and all add- ons. The provider must show the additional costs associated with providing care to the target population.

APD Adult Foster Care- Medicaid reimbursement rates for Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process. An individual's assessed

needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, the LOCUS and LSI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need.

All policies and procedures described in this SPA are time limited to no later than the termination of the Federal public health emergency, including extensions.

TN. 20-0013

Effective Date : 3/1/20

Approval Date: 7/16/20

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0014- Ambulance rate

Effective Date : 3/1/20

Approval Date: 7/30/20

Refer to approval package for the entire document

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon’s Medicaid state plan, as described below:

Please describe the modifications to the timeline. Tribal entities are informed of any urgent SPAs or waivers via our monthly Tribal Meetings and DTLL process however, instead of the 90 day consultation time periods the agency requests expediated review due to the urgent nature of the SPA, and continues discussions after submission of the SPA.

Section E – Payments

Other:

4. Other payment changes:

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) **Ambulance Treat in place rate:** Increase reimbursement for CMS HCPCS code A0998 ‘aid call’ or Treat-in- place to equal the higher level of service CMS HCPCS code A0427. Due to COVID-19 these routine ‘aid calls’ are becoming more complex, take more time and utilize more PPE resources more similar to the higher level A0427 ALS1 code. The services included in CMS HCPCS codes A0427 are the same services performed in the A0998 ‘aid call’ but without transport. The current rate for Aid calls or treat-in-place calls is \$54.45, the enhanced rate will be equal to CMS HCPCS code A0427 fee of \$420.62.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0015- 1915(k) retainer pmt
8/4/20

Effective Date : 3/1/20

Approval Date:

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. Oregon, has an approved 1135 waiver which allows modified Tribal consultation timelines. A DTLL will provide notification and consultation will continue after submission of this SPA.

Section E – Payments

4. X Other payment changes:

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions.

The ability to make retainer payments for 3 episodes of 30 days to the following 1915(k) providers for the provision of attendant care services: Agency-operated attendant care providers and Adult Day Services providers, to maintain capacity during the public health emergency (PHE).

The ability to make retainer payments for 3 episodes of 30 days to the following 1915(k) providers for the acquisition, maintenance and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks: Positive Behavioral Support Services providers, to maintain capacity during the public PHE.

- a. Retainer payments may be provided in circumstances in which facility closures are necessary due to COVID-19 containment efforts.
- b. Retainer payments attributable to each individual may be provided in circumstances in which attendance and utilization for the services drops below 75% of the monthly average for a 3-month period specified by APD which is December 2019 – February 2020 and ODDS which is October – December 2019.
- c. Retainer payments will not exceed the anticipated 75% of monthly average of total billing and will be attributable to individuals and not paid to agencies as a lump sum.

*For ODDS –

Total billing means billing by person, by service. We look at the average of an individual service provided by each provider agency for an individual for October – December 2019. Then - we will pay up to 75% if the month's billing is less than 75% of the October – December 2019 average. This process will occur by person and by service.

For APD -

Total billing means APD agreed to reimburse Adult Day Service Programs 75% of their average total monthly revenue (from December 2019-February 2020) for a three-month period running from mid-March through mid-June. Total average revenue may be from any source other than Oregon's Developmental Disabilities program.

OHA/DHS will require an attestation from the provider:

- a. Acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred as identified in a state or federal audit or any other

authorized third-party review;

b. That they will not lay off staff, and will maintain wages at existing levels;

c. That they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to PHE.

If a provider has not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess will be recouped.

If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0017- Interpreter services

Effective Date : 9/8/20

Approval Date: 11/17/20

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. Tribal entities are informed of any urgent SPAs or waivers via our monthly Tribal Meetings and DTLL however instead of the 30, 60, 90 day time periods the agency requests expedited review due to the urgent nature of the SPA.



Section E – Payments

4. Other payment changes:

Please describe.

Reimbursement for language assistance services

OHA will reimburse providers for interpreters required for limited and non-English speaking members and/or deaf/hard of hearing members, when these services are necessary and reasonable to communicate effectively with members regarding health needs. Interpreter services can only be covered in conjunction with another covered OHP service or medically necessary follow-up visit(s) to the initial covered service.

Providers must use the following code when billing for reimbursement for interpreters for both deaf/hard of hearing members, and for language interpreters required for non-English speaking members:

T1013 Sign language or oral interpreter services at \$60/event

Hospitals may obtain reimbursement for interpreting costs provided for outpatient care but not for inpatient care. Hospitals, home health agencies, rural health clinics, FQHCs, Indian Health Centers, and long-term care facilities may not claim reimbursement for language services, as they are considered part of the facilities’ overhead and administrative costs or are included in their bundled or cost based rate payment rates.

To be reimbursable the language assistance service must be provided by a qualified or certified interpreter as described in Oregon Revised Statute, chapter 413.

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions.

TN. 20-0017- Interpreter services Effective

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 20-0018- Vaccine rate

Effective Date : 3/1/20

Approval Date: 3/16/21

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. Tribal entities are informed of any Disaster relief SPAs or waivers via our monthly Tribal meetings and distribution of the DTLL. Instead of a 30-90 day consultation period the agency requests expedited review due to the nature of the SPA.

Section D – Benefits

Benefits:

1. The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

[Empty box for optional benefits]

2. X The agency makes the following adjustments to benefits currently covered in the state plan:

Allow licensed practitioners to order Medicaid Home Health services, including Advanced Practice Registered Nurses and Physician Assistants as authorized by their scope of practice. This would also

allow these practitioners to order the other components of HH services (HH aide services, nursing services and PT/OT/Speech, equipment and supplies).

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Section E – Payments

4. Other payment changes:

Please describe.

Effective 12/15/20 Payment for administration of COVID-19 immunizations are made at 100% of the Medicare rate, including any future Medicare updates or changes to their rates.

This includes all state plan outpatient program sections, including providers allowed to administer vaccination under Oregon’s scope of practice laws.

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions.

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _____ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section E – Payments

Other:

4. X Other payment changes:

Please describe.
Update to the approved language of DR SPA 20-0010 to be effective 1/1/2021.

2) For Tribal 638 and Urban Indian Health programs utilizing PPS:
At the option of the health program, provide an enhanced PPS rate during the duration of the public health emergency. Each tribal 638/urban Indian health program’s enhanced PPS rate will be calculated and updated monthly and retrospectively and will be determined by dividing total Medicaid FFS billing for services rendered during the analogous calendar month in 2019 by the total number of Medicaid patient encounters during the current billing month” analogous with the 2019 reimbursement month.

All policies and procedures describe in this SPA are time limited to no later than the

termination of the national public health emergency, including any extensions.

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 21-0006-BH rate increase

Effective Date : 7/1/20

Approval Date: 4/8/21

Refer to approval package for entire document.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here. The 10% payment rate increase for mental health and substance use disorder services is effective July 1, 2020 and will terminate on the earlier of the end of the PHE or June 30, 2021

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. Tribal entities are informed of any urgent SPAs or waivers via our monthly Tribal Meetings and DTLL process however, instead of the 90 day consultation time periods the agency requests expedited review due to the urgent nature of the SPA, and continues discussions after submission of the SPA.

Section E – Payments

Other:

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extension or June 30, 2021 whichever is first. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 10% rate increase for Adult Mental Health Residential; Substance Use Disorder Residential Programs; Child and Adolescent Mental Health Residential providers. This increase is not duplicative of the Reserve Service Capacity payments approved under TN 20-0010.

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. Tribal entities are informed of any urgent SPAs or waivers via our monthly Tribal Meetings and DTLL process however, instead of the 90 day consultation time periods the agency requests expediated review due to the urgent nature of the SPA, and continues discussions after submission of the SPA.

Section E – Payments

4. X Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extension or June 30, 2021 whichever is first. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

Reimbursement for NEMT is \$13.23 per 30-minute unit for trips associated with a drive

through COVID vaccination site. For the NEMT service to be reimbursable at this rate, the Medicaid beneficiary arrives in the provider vehicle and receives the COVID-19 vaccination without exiting the provider vehicle.

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 21-0014-COVID mAbs treatment

Effective Date : 1/1/21

Approval Date: 10/1/21

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- d. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- e. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- f. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

For this specific SPA, Oregon submitted the DR SPA on August 19, 2021. Oregon started its Trial consultation period with the distribution of the DTLL on August 23, 2021. Tribal entities have 60 days to review and make comments or request to schedule a face-to-face consultation with the entire 90 period to be completed by November 21, 2021.

Section D – Benefits

1. The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

The state will cover COVID-19 the administration of monoclonal antibody treatment or any drug treatment authorized under an FDA Emergency Use Authorization regardless of rebate or language in Attachment 3.1-A of the Oregon Medicaid State Plan that precludes coverage of investigational/experimental treatments.

The state will cover prescribed drugs that are not covered outpatient drugs when the drug is authorized for use in the United States by the FDA and when the state determines coverage is medically necessary due to a recognized critical drug shortage.

Providers that are Medicaid enrolled and qualified based upon their scope of practice and subject to applicable laws may receive reimbursement for administering monoclonal antibody treatment or any other COVID-19 drug treatment authorized above.

2. The agency makes the following adjustments to benefits currently covered in the state plan:

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Section E – Payments

Optional benefits described in section D:

1. Newly added benefits described in Section D are paid using the following methodology:

a. Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. Other:

Describe methodology here.

Reimbursement for the COVID-19 administration of monoclonal antibody treatment or any drug treatment authorized under an FDA Emergency Use Authorization are made at 100% of the Medicare rate, including any future Medicare updates or changes to their rates. Monoclonal antibody treatment is reimbursed with a weighted geographical average of the Medicare rates. Reimbursement can be accessed on our web at <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>. Coverage guidance can be accessed at <https://www.oregon.gov/oha/HSD/OHP/Tools/Oregon%20Medicaid%20COVID-19%20Provider%20Guide.pdf>

All policies and procedures described in this SPA are time limited to no later than termination of the national public health emergency, including any extensions.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 21-0018-10% increase extended

Effective Date : 7/1/21

Approval Date: 12/21/21

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- g. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- h. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- i. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. For Disaster Relief SPA's, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distributed the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. Oregon distributed the DTLL on 2/5/21 for the original submission of 21-0006 and distributed a similar DTLL for this extension on 11/30/21.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

a. Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

Please list all that apply.

a. Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

By the following factors:

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extension. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 10% rate increase for Adult Mental Health Residential; Substance Use Disorder Residential Programs; Child and Adolescent Mental Health Residential providers. This increase is not duplicative of the Reserve Service Capacity payments approved under TN 20-0010 or 21-0006.

Payments for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

4. ____ Other payment changes:

Please describe.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 22-0001 -BRS increase

Effective Date : 1/1/21

Approval Date: 2/11/22

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPA's, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distributed the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. The DTLL for this SPA was distributed to the Tribal leaders on 12/23/21.

Section E – Payments

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extension. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 10% rate increase for Behavior Rehabilitation Services (BRS) Program providers. Theses providers include social services staff, child care staff and program coordinators of licensed BRS entities under current state plan TN 04-09. This increase is not duplicative of any Disaster relief SPAs (21-0006, 21-0018) previously submitted and approved.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 22-0004 -ODDS 5% increase

Effective Date : 1/1/21

Approval Date: 3/30/22

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPA's, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distributed the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation.

Section E – Payments

4. X Other payment changes:

All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extension or June 30, 2022 whichever is first. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 5% increase for ODDS services and settings such as Adult Group Home (AGH), Supported Living, In Home attendant care, Behavioral Support Services, Group Care Homes for Children (GCH), Children's DD Foster Care, and Day Support Activities. This increase is not duplicative of any Disaster relief SPAs (20-0010) previously submitted and approved.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 22-0014 -ODDS 5% increase-extend

Effective Date : 7/1/22

Approval Date: 9/23/22

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPAs, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distribute the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. The DTLL was distributed to the Tribal leaders on 7/1/22. There has not been a request for additional meetings or any comments.

Section E – Payments

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. This will extend the time limited increase for ODDS services from July 1, 2022, to the end of the PHE period or September 30, 2022, whichever is first. This temporary rate method accounts for the extraordinary

expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 5% increase for ODDS services and settings such as Adult Group Home (AGH), Behavioral Support Services, Group Care Homes for Children (GCH), Children's DD Foster Care, and Day Support Activities. This increase is not duplicative of any Disaster relief SPAs (20-0010) previously submitted and approved.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN. 22-0020- NF rate

Effective Date : 1/1/21

Approval Date: 11/9/22

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPAs, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distribute the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. The DTLL was distributed to the Tribal leaders on 4/14/20. There has not been a request for additional meetings or any comments.

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited to no later than 1/1/21 through 6/30/23 or the termination of the national public health emergency, including any extensions. These temporary rate methods account for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

Rates for nursing facilities, assisted living facilities, residential care facilities are increased by 5%.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN 22-0022 K plan rate

Effective:7/1/22

Approved:12/2/22

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPAs, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distribute the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. The DTLL was distributed to the Tribal leaders on 6/25/22. There has not been a request for additional meetings or any comments.

Section E – Payments

4. X Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. This will increase rates for functional needs tier levels from July 1, 2022, to the end of the PHE period. The Public Health Emergency caused extraordinary expenses for providers and highlighted the need for this change.

Increase reimbursements for K plan services for adult group home, day support activities and Transportation that represents and overall increase of 17%. The increased rates are as follows:

Adult group home

Category	3 or fewer residents	4-5 residents	6+ residents
1	\$292.05	\$228.40	\$156.30
2	\$398.79	\$339.97	\$184.34
3	\$545.83	\$422.35	\$275.60
4	\$667.16	\$544.49	\$312.13

Day Support Activities

Provider Agency Rates Per Hours:	Category 1	Category 2	Category 3	Category 4
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Group DSA- Community (OR542/W2)	\$16.70	\$20.78	\$28.96	\$38.62
Group DSA-Facility (OR542/W1,ZH)	\$11.70	\$15.33	\$18.94	\$27.51
Solo DSA OR542/RS		\$41.13		
Rate for 1:1 Group DSA community OR542/RC		\$40.48		
Rate for 1:1 group DSA Facility OR 542/R1		\$37.27		
Solo DSA(2:1) OR542/RS		\$74.52		
Rate for 2:1 Group DSA community OR542/ZC		\$68.61		
Rate for 2:1 group DSA Facility OR 542/ZF		\$65.04		
Community Transport				
codes	Description	Rate		
OR003	Taxi rides	Cost of bus pass, voucher, etc., including any processing fees applied by the vendor		
OR004	Per mile reimbursement for PSW	\$.56/mile		
OR005	Mileage Transport Agency	2.03/mile		
OR554	Bus passes	Cost of bus pass, voucher, etc., including any processing fees applied by the vendor		
These rates do not include the temporary 5% increase authorized in TN 22-0004 and extended in 22-0023 request.				

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN 22-0023 5% rate extended

Effective 10/1/22

Approved 12/9/22

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. _____ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPAs, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distribute the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. The DTLL was distributed to the Tribal leaders on 7/1/22. There has not been a request for additional meetings or any comments.

Section E – Payments

- 4. X Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. This will extend the time limited increase for ODDS services from October 1, 2022, to the end of the PHE period or December 31, 2022, whichever is first. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 5% increase for ODDS services in the following settings, Adult Group Home (AGH), Behavioral Support Services, Group Care Homes for Children (GCH), Children’s DD Foster Care, and Day Support Activities. This increase is not duplicative of any Disaster relief SPAs (20-0010, 22-0004, 22-0014) previously submitted and approved.

Section 7 – General Provisions**7.5. Medicaid Disaster Relief for the COVID-19 National Emergency**

TN 22-0026 NF incentive program

Effective 11/1/22

Approved 1/27/23

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPA's, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distributed the DTLL and give the Tribal leaders 30 days to review and request to schedule

a face-to-face consultation. The DTLL went for review on 11/3/22 and is targeted to be distributed by December 3, 2022.

Section E – Payments

4. Other payment changes:

Please describe.

All policies and procedures described in this SPA are time limited to no later than the termination of the national public health emergency, including any extension. Hospital Decompression Incentive payments will be made to Nursing Facilities and Community-Based Settings authorized under 1915(i) and 1915(k) authorities including, Adult Foster Homes, Group Care Homes, Residential Care Facilities, and In-Home Care Agencies. Incentive payments will be made to a provider for new admissions of individuals who are discharged from a hospital setting or nursing facility (NF) during the period November 1, 2022 – April 30, 2023. Participating providers must have a vacancy, confirm that the individual is not returning to the provider from a hospital/NF stay and confirm the ability to safely meet the individual’s needs upon discharge from the hospital/NF. Providers must agree to not discharge/end services for the individual within 90 days of the date of admission to the setting. The incentive will be made in two separate payments, totaling \$5,000.00. The first will be in the amount of \$2,000.00. Providers have 30 days from the date of discharge from the hospital/NF to request the first payment. The second and final payment of \$3,000.00 will be made upon confirmation that the individual met the criteria above. Providers must request the second payment within 120 days from the date of discharge from the hospital/NF. (i.e., Providers have 30 days to request the second payment once the individual has been with them for 90 days.) The incentive payment is paid in addition to the scheduled rate for services provided to the individual under these authorities. Incentive payments are not limited to payment for individuals that are currently enrolled or have been determined eligible for 1915(i), 1915(k) or nursing facility services and are enrolled in a Medicaid benefit group that is eligible to receive services under these authorities.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN 22-0028 5% increase extension

Effective 1/1/23

Approved 2/24/23

Refer to approval package for entire document.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPAs, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distribute the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation. This is the 5th extension of this payment and there has been a DTLL distribution with the 4 prior SPAs with no comments from the Tribes. The DTLL for this SPA will be distributed to the Tribal leaders in the next 3 weeks.

Section E – Payments

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. This will extend the time limited increase for ODDS services from January 1, 2023, to the end of the PHE period or June 30, 2023, whichever is first. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 5% increase for ODDS services in the following settings, Adult Group Home (AGH), Behavioral Support Services, Group Care Homes for Children (GCH), Children’s DD Foster Care, and Day Support Activities. This increase is not duplicative of any Disaster relief SPAs (20-0010, 22-0004,

22-0014, 22-0023) previously submitted and approved.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

TN 23-0001 I.H.S option

Effective 1/1/23

Approved 3/24/23

Refer to approval package for entire document

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline For Disaster Relief SPA's, the state requested and was approved an 1135 waiver allowing for modified consultation time frames. Under the traditional process the agency will send a DTLL and finish a 90 day consultation period prior to the submission of the SPA. Under the modified timelines the agency will submit the SPA first and then distributed the DTLL and give the Tribal leaders 30 days to review and request to schedule a face-to-face consultation.

Section E – Payments

4. X Other payment changes:

Please describe.

All policies and procedures described in this SPA are time limited to no later than the termination of the national public health emergency, including any extension.

AI/AN Tribal Clinics with a 638 designation that are enrolled as a Federally qualified Health Center may be paid an Alternative Payment Methodology (APM) for FQHC services that is equivalent to the Indian Health Service MOU rate, published annually in the Federal Register. Each individual tribal FQHC must agree to the APM, and the amount paid under this APM is at least equal to the Prospective Payment System (PPS) rate.

Section 7 – General Provisions

7.5.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective the day after the end of the PHE until 06/30/2023, the agency temporarily extends the following election(s) of section 7.5 (approved on 11/9/2022 in SPA Number 22-0020) of the state plan:

Section E – Payments

Other:

4. Other payment changes:

Please describe:

All policies and procedures describe in this SPA are time limited to 5/12/2023 through 6/30/23. These temporary rate methods account for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

Rates for nursing facilities, assisted living facilities, residential care facilities are increased by 5%.

TN 23-0018

Approval Date:6/14/23

Effective Date: 5/12/2023

Supersedes:

Section 7 – General Provisions

7.5.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective the day after the end of the PHE until 06/30/2023, the agency temporarily extends the

following election(s) of section 7.5 (approved on 02/24/2023 in SPA Number 22-0028) of the state plan:

Section E – Payments

Other:

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. This will extend the time limited increase for ODDS services from May 12, 2023 through June 30, 2023. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 5% increase for ODDS services in the following settings, Adult Group Home (AGH), Behavioral Support Services, Group Care Homes for Children (GCH), Children’s DD Foster Care, and Day Support Activities. This increase is not duplicative of any Disaster relief SPAs (20-0010, 22-0004, 22-0014, 22-0023) previously submitted and approved.

TN 23-0013
Supersedes TN: NEW

Approval Date: 5/10/23
Effective Date: 5/12/2023

Section 7 – General Provisions

7.5.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective the day after the end of the PHE until 06/30/2023, the agency temporarily extends the following election(s) of section 7.5 (approved on 04/6/2023 in SPA Number 23-0005) of the state plan:

Section E – Payments

Other:

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. HCBS providers may be eligible between May 12, 2023, and June 30, 2023.

Enhanced Wage Add-on Program

The Enhanced Wage Add-on Program is designed to support Home and Community Based Services (HCBS) providers with retention of Care givers by paying a starting wage of \$15 per hour for all Caregivers, with an increase to \$15.50 per hour by the second year of the 2021-2023 biennium. HCBS providers include Adult Day Services.

HCBS providers must submit documentation that they are paying a starting wage of \$15 per hour for all Caregivers, with an increase to \$15.50 per hour by the second year of the 2021-2023 biennium prior to being eligible for the Enhanced Wage Add-on Program. HCBS providers who meet the criteria of the Program will receive an add-on of 10% of the Medicaid rate.

HCBS providers may be eligible between May 12, 2023, and June 30, 2023

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

The state assures coverage of COVID-19 vaccines and administration of the vaccines.¹

The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

TN No. 22-0011

Approval Date: 7/22/22

Effective Date: 3/11/21

Supersedes TN No. NEW

¹ The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
SECTION 7 - GENERAL PROVISIONS

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

X The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines. Additional Information (Optional):

Reimbursement

X The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for

Rates as established in Disaster relief SPA TN 20-0018 for Vaccine administration rate through the end of the PHE.

See establishing rates for the period from the end of the PHE through the end of the ARP period.

After the ARP period has expired the Rates revert back to state plan rates for VFC authorized under Attachment 4.19-B, page 28, and non VFC vaccines Attachment 4.19-B, page 1.

COVID-19 vaccines and their administration for each applicable Medicaid benefit:

X The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
SECTION 7 - GENERAL PROVISIONS

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

- Medicare national average, OR
 Associated geographically adjusted rate.

The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

Payment for administration of COVID-19 immunizations from the end of the PHE through the end of the ARP period are made at 100% of the Medicare rate, including any future Medicare updates or changes to their rates. This includes all state plan outpatient program sections, including providers allowed to administer vaccination under Oregon's scope of practice laws.

The state's fee schedule is the same for all governmental and private providers.

The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

--

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

 The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

 X The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

 X The state's rate is as follows and the state's fee schedule is published in the following location :

Counseling that does not occur during the vaccine administration visit is reimbursed under the Evaluation and Management (E/M) code appropriate for the time spent counseling. The statewide fee schedule can be found at:
<https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

PRA Disclosure Statement Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

X The state assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

X The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Home test products- OHP will cover up to eight units per month without a primary care provider's (PCP) order or prior authorization. OHP may cover more than eight units per month when ordered by the PCP as a necessary component of an individualized care plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
SECTION 7 - GENERAL PROVISIONS

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act (Cont)

Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

Established Lab codes are paid at currently approved state plan rates Attachment 4.19-B, page 1
New COVID-19 codes U0001-U0005, DR SPA 20-0010 @ 100% of Medicare

The state is establishing rates for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

Medicare national average, OR

Associated geographically adjusted rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act (Cont)

 The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following

location

 X The state's fee schedule is the same for all governmental and private providers.

 The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

 The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure

Statement Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

X The states assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

X The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

X Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Coverage for a Condition that May Seriously Complicate the Treatment of COVID (Cont)

X The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

X The states assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

X The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

X Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

X The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Coverage for a Condition that May Seriously Complicate the Treatment of COVID (Cont)

Additional Information (Optional):

Reimbursement

The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

DR SPA 21-0014 Monoclonal Antibody treatment, all other treatment, including specialized equipment and therapies as authorized under State Medicaid Plan, Attachment 4.19-B for the specific program (i.e physician, PT, DME, etc) and Attachment 4.19-A for inpatient hospital services.

The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rates or fee schedule is the same for all governmental and private providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

SECTION 7 - GENERAL PROVISIONS

Coverage for a Condition that May Seriously Complicate the Treatment of COVID (Cont)

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

PRA Disclosure Statement Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Section 7.5.B-

Temporary extensions to Disaster Relief PHE SPAs

Section 7 – General Provisions

7.5.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective the day after the end of the PHE until 06/30/2023, the agency temporarily extends the following election(s) of section 7.5 (approved on 02/24/2023 in SPA Number 22-0028) of the state plan:

Section E – Payments

Other:

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. This will extend the time limited increase for ODDS services from May 12, 2023 through June 30, 2023. This temporary rate method accounts for the extraordinary expenses these providers have been experiencing in managing the COVID-19 emergency.

1) 5% increase for ODDS services in the following settings, Adult Group Home (AGH), Behavioral Support Services, Group Care Homes for Children (GCH), Children’s DD Foster Care, and Day Support Activities. This increase is not duplicative of any Disaster relief SPAs (20-0010, 22-0004, 22-0014, 22-0023) previously submitted and approved.

TN 23-0013
Supersedes TN: NEW

Approval Date: 5/10/23
Effective Date: 5/12/2023

Section 7 – General Provisions

7.5.B. Temporary Extension to the Disaster Relief Policies for the COVID-19 National Emergency

Effective the day after the end of the PHE until 06/30/2023, the agency temporarily extends the following election(s) of section 7.5 (approved on 04/6/2023 in SPA Number 23-0005) of the state plan:

Section E – Payments

Other:

4. Other payment changes:

Please describe.

All policies and procedures describe in this SPA are time limited. HCBS providers may be eligible between May 12, 2023, and June 30, 2023.

Enhanced Wage Add-on Program

The Enhanced Wage Add-on Program is designed to support Home and Community Based Services (HCBS) providers with retention of Care givers by paying a starting wage of \$15 per hour for all Caregivers, with an increase to \$15.50 per hour by the second year of the 2021-2023 biennium. HCBS providers include Adult Day Services.

HCBS providers must submit documentation that they are paying a starting wage of \$15 per hour for all Caregivers, with an increase to \$15.50 per hour by the second year of the 2021-2023 biennium prior to being eligible for the Enhanced Wage Add-on Program. HCBS providers who meet the criteria of the Program will receive an add-on of 10% of the Medicaid rate.

HCBS providers may be eligible between May 12, 2023, and June 30, 2023.

Section 8
ACA SPA

Refer to supersede pages to determine replacement pages

Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Options for Coverage	
Optional Coverage of Parents and Other Caretaker Relatives	S51
42 CFR 435.220 1902(a)(10)(A)(ii)(I)	
Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

TN No. 13-0012-MM

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Eligibility Groups - Options for Coverage

Reasonable Classification of Individuals under Age 21

S52

42 CFR 435.222, 1902(a)(10)(A)(ii)(I) and 1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

Be under age 21, or a lower age, as defined within the reasonable classification.

Have household income at or below the standard established by the state, if the state has an

income standard for the reasonable classification.

Not be eligible and enrolled for mandatory coverage under the state plan.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

Yes No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

Yes No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

Section 8.1 MAGI based Eligibility

OMB 0938-1148 Transmittal 13-0012

Current Coverage of All Children under a Specific Age

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

Yes No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

Yes No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children	S11
<input checked="" type="checkbox"/> Individuals for whom public agencies are assuming full or partial financial responsibility	
<input checked="" type="checkbox"/> Individuals placed in foster care homes by public agencies Indicate the age which applies: <input checked="" type="checkbox"/> Under age 21 <input type="checkbox"/> Under age 20 <input type="checkbox"/> Under age 19 <input type="checkbox"/> Under age 18 <input type="checkbox"/> Individuals placed in foster care homes by private, non-profit agencies	
<input checked="" type="checkbox"/> Individuals placed in private institutions by public agencies Indicate the age which applies: <input checked="" type="checkbox"/> Under age 21 <input type="checkbox"/> Under age 20 <input type="checkbox"/> Under age 19 <input type="checkbox"/> Under age 18 <input type="checkbox"/> Individuals placed in private institutions by private, non-profit agencies	
<input type="checkbox"/> Individuals in adoptions subsidized in full or part by a public agency	

Section 8.1 MAGI based Eligibility

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Individuals in nursing facilities, if nursing facility services are provided under this plan

Indicate the age which applies:

Under age 21 Under age 20 Under age 19 Under age 18

Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), if these services are provided under this plan.

Indicate the age which applies:

Under age 21 Under age 20 Under age 19 Under age 18

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Indicate the age which applies:

Under age 21 Under age 20 Under age 19 Under age 18

Other reasonable classifications

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Individuals placed in foster care homes by public agencies	
<input type="checkbox"/>	Income standard used
<input type="checkbox"/>	Minimum income standard The minimum income standard for this classification of children is the AFDC payment standard in Effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.
<input type="checkbox"/>	Maximum income standard No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.
<input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/>	No income test was used (all income was disregarded) for this classification under:
<input type="checkbox"/>	The Medicaid state plan as of March 23, 2010.
<input checked="" type="checkbox"/>	The Medicaid state plan as of December 31, 2013

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Section 8.1 MAGI based Eligibility

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A Medicaid 1115 Demonstration as of March 23, 2010.

A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

This classification does not use an income test (all income is disregarded).

The minimum standard.

Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals placed in private institutions by public agencies

Income standard used

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in Effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this classification under:

The Medicaid state plan as of March 23, 2010

The Medicaid state plan as of December 31, 2013.

A Medicaid 1115 Demonstration as of March 23, 2010.

A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

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Section 8.1 MAGI based Eligibility

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- This classification does not use an income test (all income is disregarded).
- The minimum standard.
- Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals in nursing facilities, if nursing facility services are provided under this plan

- Income standard used
 - Minimum income standard
The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.
 - Maximum income standard
No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013
- Yes No
 - No income test was used (all income was disregarded) for this classification under:
 - The Medicaid state plan as of March 23, 2010.
 - The Medicaid state plan as of December 31, 2013.
 - A Medicaid 1115 Demonstration as of March 23, 2010.
 - A Medicaid 1115 Demonstration as of December 31, 2013.
 - The state's maximum standard for this classification of children is no income test (all income is disregarded).
- Income standard chosen
Individuals qualify under this classification under the following income standard:
 - This classification does not use an income test (all income is disregarded).
 - The minimum standard.
 - Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

- Income standard used
 - Minimum income standard
The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.
 - Maximum income standard

Section 8.1 MAGI based Eligibility

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No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this classification under:

The Medicaid state plan as of March 23, 2010.

The Medicaid state plan as of December 31, 2013.

A Medicaid 1115 Demonstration as of March 23, 2010.

A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

This classification does not use an income test (all income is disregarded).

The minimum standard.

Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

Yes No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

Yes No

There is no resource test for this eligibility group

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

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Eligibility Groups - Options for Coverage	
Children with Non IV-E Adoption Assistance	S53

42 CFR 435.227 1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

- Yes No
- The state attests that it operates this eligibility group in accordance with the following provisions:
 - Individuals qualifying under this eligibility group must meet the following criteria:
 - The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;
 - Are under the following age (see the Guidance for restrictions on the selection of an age):
 - Under age 21
 - Under age 20
 - Under age 19
 - Under age 18
 - MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

- Yes No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

- Yes No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior To the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state Plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23,

2010 or December 31, 2013.

- Yes No

Income standard used for this eligibility group

- Minimum income standard

The minimum income standard for this eligibility group must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

- Maximum income standard

Section 8.1 MAGI based Eligibility

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No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this eligibility group under:

The Medicaid state plan as of March 23, 2010.

The Medicaid state plan as of December 31, 2013.

A Medicaid 1115 Demonstration as of March 23, 2010.

A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

This eligibility group does not use an income test (all income is disregarded).

Another income standard higher than both the minimum income standard and the effective income level for this eligibility group in the state plan as of March 23, 2010, converted to a MAGI-equivalent.

There is no resource test for this eligibility group.

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Options for Coverage	
Children with Non IV-E Adoption Assistance	S50
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

Section 8.1 MAGI Eligibility Groups - Mandatory Coverage

Former Foster Care Children 42 CFR 435.150, 1902(a)(10)(A)(i)(IX)

The state covers the mandatory former foster care children in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26
2. Were in foster care upon attaining age 18 or a higher age at which the State's or tribe's foster care assistance ends under Title IV_E of the Act (up to age 21).
3. Are described under either Section B or C.

B. Individuals Covered

For individuals turning 18 before January 1, 2023:

1. The state covers individual who:
 - a. upon attaining age 18 or a higher age at which the State's or tribe's foster care assistance ends under Title IV-E of the Act (up to age 21) were:
 - i. In foster care under the responsibility of the state or Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) and
 - ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration, and
 - b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or higher age at which the state's or Tribe's foster care assistance ends under Title IV-E of the Act,. And meet the following criteria:

- a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the states or Tribes foster care assistance ends.
- b. They were placed by the state ir Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or higher age at which the state's or tribe's foster care assistance ends.

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Supersedes TN No. 13-0012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

B.2. (Cont)

b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during foster care period in which they turned 18 or higher age at which the state's or tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individual who:

a. upon attaining age 18 or a higher age at which the State's or tribe's foster care assistance ends under Title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration, and

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or higher age at which the state's or Tribe's foster care assistance ends under Title IV-E of the Act,. And meet the following criteria:

a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the states or Tribes foster care assistance ends.

b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or higher age at which the state's or tribe's foster care assistance ends.

b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during foster care period in which they turned 18 or higher age at which the state's or tribe's foster care assistance ends.

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Mandatory Coverage

Adult Group

S32

1902(a)(10)(A)(i)(VIII), 42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes No

Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

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Section 8.1 MAGI based Eligibility

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Eligibility Groups - Mandatory Coverage

Infants and Children under Age 19

S30

42 CFR 435.118

1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)

1902(a)(10)(A)(ii)(IV) and (IX)

1931(b) and (d)

Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.

The state attests that it operates this eligibility group in accordance with the following provisions:

Children qualifying under this eligibility group must meet the following criteria:

Are under age 19

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

Income standard used for infants under age one

Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for Determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for infants under age one is 133% FPL

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s)

for

Infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

Attachment submitted

The state's maximum income standard for this age group is:

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 185% FPL

Enter the amount of the maximum income standard: % FPL 185% of FPL

- Income standard chosen
The state's income standard used for infants under age one is:
 - The maximum income standard
 - If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-Related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as Of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - Another income standard in-between the minimum and maximum standards allowed, provided it is higher than
the effective income standard for this age group in the state plan as of March 23, 2010.
- Income standard for children age one through age five, inclusive
 - Minimum income standard

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The minimum income standard used for this age group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

Attachment submitted

The state's maximum income standard for children age one through five is:

The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 133 % FPL

Income standard chosen

The state's income standard used for children age one through five is:

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children

age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and

if not chosen as the maximum income standard, the state's highest effective income level for coverage of children

age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

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If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age six through age eighteen, inclusive

Minimum income standard

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

Attachment submitted

The state's maximum income standard for children age six through eighteen is:

The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

133% FPL

Income standard chosen

The state's income standard used for children age six through eighteen is:

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The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of Children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

Yes No

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Section 8.1 MAGI based Eligibility

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Eligibility Groups - Mandatory Coverage

Pregnant Women

S28

42 CFR 435.116, 1902(a)(10)(A)(i)(III) and (IV), 1902(a)(10)(A)(ii)(I), (IV) and (IX), 1931(b) and (d) 1920

Pregnant Women - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

Yes No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for this eligibility group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

Attachment submitted

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV)(institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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Section 8.1 MAGI based Eligibility

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The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

The amount of the maximum income standard is: 185% FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women

Receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by

a qualified entity.

Yes No

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Section 8.1 MAGI based Eligibility

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AFDC Income Standards

S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	399
2	515
3	611
4	747
5	872
6	998
7	1,114
8	1,230
9	1,321
10	1,456

Additional incremental amount

- Yes No

Increment amount \$ 136

The dollar amounts increase automatically each year

- Yes No

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AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	310
2	395
3	460
4	565
5	660
6	755
7	840
8	925
9	985
10	1,090

Additional incremental amount

- Yes No

Increment amount \$ 105

The dollar amounts increase automatically each year

- Yes No

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Section 8.1 MAGI based Eligibility

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AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	399
2	515
3	611
4	747
5	872
6	998
7	1,114
8	1,230
9	1,321
10	1,456

Additional incremental amount

- Yes No

Increment amount \$ 136

The dollar amounts increase automatically each year

- Yes No

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AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Additional incremental amount

Yes No

Increment amount \$ _____

The dollar amounts increase automatically each year

Yes No

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Section 8.1 MAGI based Eligibility

OMB 0938-1148 Transmittal 13-0012

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Additional incremental amount

- Yes No

Increment amount \$ _____

The dollar amounts increase automatically each year

- Yes No

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Section 8.1 MAGI based Eligibility

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TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	326
2	416
3	485
4	595
5	695
6	796
7	886
8	976
9	1,039
10	1,150

Additional incremental amount

- Yes No

Increment amount \$ 110

The dollar amounts increase automatically each year

- Yes No

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

MAGI-equivalent TANF Payment Standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	519
2	676
3	811
4	988
5	1,155
6	1,322
7	1,479
8	1,635
9	1,765
10	1,943

Additional incremental amount

- Yes No

Increment amount \$ 177

The dollar amounts increase automatically each year

- Yes No

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Mandatory Coverage

Parents and Other Caretaker Relatives

S25

42 CFR 435.110, 1902(a)(10)(A)(i)(I), 1931(b) and (d)

Parents and Other Caretaker Relatives - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

- Individuals qualifying under this eligibility group must meet the following criteria:
 - Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

- This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.
- Options relating to the definition of caretaker relative (select any that apply):
- Options relating to the definition of dependent child (select the one that applies):
 - The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.
 - The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):
 - Have household income at or below the standard established by the state.
 - MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.
- Income standard used for this group
 - Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

 - The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

Attachment submitted
- Maximum income standard

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

Attachment submitted

The state's maximum income standard for this eligibility group is:

- The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- A percentage of the federal poverty level: _____%
- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- Other dollar amount

Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- Another income standard in-between the minimum and maximum standards allowed

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state

assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Options for Coverage	
Individuals Eligible for Family Planning Services	S59
1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	
Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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Eligibility Groups - Options for Coverage

Independent Foster Care Adolescents

S57

42 CFR 435.226, 1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under the following age

Under age 21

Under age 20

Under age 19

Were in foster care under the responsibility of a state on their 18th birthday.

Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

Have household income at or below a standard established by the state

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

Yes No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

Yes No

The state covers children under this eligibility group, as follows (selection may not be more liberal than the most liberal coverage in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013):

All children under the age selected

A reasonable classification of children under the age selected:

Income standard used for this eligibility group

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010.

Yes No

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

The minimum standard.

This eligibility group does not use an income test (all income is disregarded).

Another income standard higher than the minimum income standard.

There is no resource test for this eligibility group.

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Options for Coverage

Individuals with Tuberculosis

S55

1902(a)(10)(A)(ii)(XII)

1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

Yes No

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Section 8.1 MAGI based Eligibility

OMB 0938-1148

Transmittal 13-0012

Eligibility Groups - Options for Coverage
Optional Targeted Low Income Children

S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

Yes No

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Section 8.2 Eligibility process

Transmittal 15-0004

General Eligibility Requirements

Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

Attachment submitted

An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

Attachment submitted

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

Attachment submitted

An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

Attachment submitted

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

Yes No

Section 8.2 Eligibility process

Transmittal 15-0004

Indicate the other electronic means below:

Name of Method	Description
Fax	Paper application or fillable PDFs can be sent in via fax to the processing center
Email	Paper applications or fillable PDFs can be attached to an email and submitted to the processing center

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

- Parents and Other Caretaker Relatives
- Pregnant Women
- Infants and Children under Age 19

Redetermination Processing

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

- Once every 12 months
- Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

- Once every 12 months
- Once every 6 months
- Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

Section 8.3 MAGI-Based Income Methodologies

Transmittal 13-0014

MAGI-Based Income Methodologies	S10
1902(e)(14) 42 CFR 435.603	
<p><input checked="" type="checkbox"/> The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.</p> <p>In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.</p> <p>In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.</p> <p>In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:</p> <p><input type="checkbox"/> The pregnant woman is counted just as herself. <input type="checkbox"/> The pregnant woman is counted as herself, plus one. <input checked="" type="checkbox"/> The pregnant woman is counted as herself, plus the number of children she is expected to deliver.</p> <p>Financial eligibility is determined consistent with the following provisions:</p> <p>When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.</p> <p>When determining eligibility for current beneficiaries, financial eligibility is based on:</p> <p><input checked="" type="checkbox"/> Current monthly household income and family size <input type="checkbox"/> Projected annual household income and family size for the remaining months of the current calendar year.</p> <p>In determining current monthly or projected annual household income, the state will use reasonable methods to:</p> <p><input checked="" type="checkbox"/> Include a prorated portion of a reasonably predictable increase in future income and/or family size. <input checked="" type="checkbox"/> Account for a reasonably predictable decrease in future income and/or family size.</p>	

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Section 8.3 MAGI-Based Income Methodologies

Transmittal 13-0014

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes No

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

Age 19

Age 19, or in the case of full-time students, age 21

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Section 8.4 Organization of agency

Transmittal 18-0007

Organization	
Designation and Authority	A1
42 CFR 431.10	

A. Single State Agency

1. State Name: Oregon

2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency: Oregon Health Authority

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name

16-0003 AG cert

Date Created

10/25/2018 10:30 AM EDT

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

a. The single state agency supervises the administration through counties or local government entities.

b. The single state agency supervises the administration through other state agencies. The other state agency implements the state plan through counties and local government entities.

c. Another state agency administers a portion of the state plan through a waiver under the Intergovernmental Cooperation Act of 1968

Intergovernmental Cooperation Act Waivers

42 CFR 431.10

A. Intergovernmental Cooperation Act Waivers

The state has the following Intergovernmental Cooperation Act Waivers:

Department of Human Services

1. Name of state agency to which responsibility is delegated: Department of Human Services
2. Date waiver granted: 7/18/2017
3. The type of responsibility delegated is (check all that apply):

- a. Conducting fair hearings
 b. Other

4. The scope of the delegation (i.e. all fair hearings) includes:

Waiver -Department of Human Services:

The Oregon Health Authority (OHA) delegates the authority to use informal resolution processes to resolve fair hearings and the authority to review and issue final fair hearing decisions following the initial decision made by an Administrative Law Judge (ALJ) for the cases for which DHS has authority. DHS has authority over fair hearing requests related to eligibility for both MAGI and non-MAGI populations as well as hearings related to Title XIX Home and Community-Based services (HCBS) administered by DHS through approved 1915(c) waivers, 1915(j) and 1915(k) state plan options. DHS also has authority over fair hearing requests related to state plan personal care services operated by DHS, Aging and People with Disabilities and Office of Developmental Disabilities Services. DHS staff can perform the review of the hearing request and use informal resolution processes to resolve fair hearing requests. DHS staff may also issue dismissal orders for fair hearing requests for which DHS has authority.

Should the Oregon Health Authority or the Department of Human Services disagree with the decision of the Office of Administrative Hearings, the Oregon Health Authority or the Department of Human Services may review the fair hearing decision for proper application/interpretation of laws, rules, and policies. If the Oregon Health Authority or the Department of Human Services finds that law, rules or policies have been improperly applied, DHS can change OAH's initial decision. However, the OAH/ALJ findings of fact may only be changed by an ALJ at OAH. Under state law, it is the Office of Administrative Hearings that "conducts" these hearings and Department of Human Services and Oregon Health Authority participates.

The Oregon Health Authority may review the fair hearing decision and propose changes, and the Department of Human Services has final order authority over MAGI eligibility, non-MAGI eligibility and HCBS benefit fair hearings decisions.

Section 8.4 Organization of agency

Transmittal 18-0007

Intergovernmental Cooperation Act Waivers

42 CFR 431.10

5. Methods for coordinating responsibilities between the agencies include:

- a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.
- b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.
- c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.
- d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.
- e. The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:
 - i. A written agreement between the agencies.
 - ii. State statutory and/or regulatory provisions.

6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.

- Yes
- No
- The Medicaid agency only reviews fair hearing decisions issued by the delegated entity with respect to the proper application of federal and state law regulations and policies. The review process is conducted by an impartial official not involved in the initial determination.

7. Additional methods for coordinating responsibilities among the agencies(optional):

There is extensive coordination for eligibility appeals (MAGI and non-MAGI) as well as services-related appeals among the Oregon Health Authority, The Department of Human Services, and The Office of Administrative Hearings. Hearing request can come through OHA or DHS (no door is the wrong door). When a request comes into DHS or OHA, the Office of Administrative Hearings is notified. Once OAH is notified their responsibilities include: scheduling the hearings, notifications to claimants and OHA/DHS staff about these hearings, communicating orders to claimants and DHS/OHA, retaining hearing files, and tracking data about the hearings. Initial appeals hearings request are assigned to DHS employees based upon MAGI, non-MAGI, or benefits related to 1915(c), 1915(j) and 1915(k) HCBS authorities, and state plan personal care services operated by DHS for the APD and I/DD populations.

For MAGI eligibility, non-MAGI eligibility and HCBS benefits cases, DHS can use informal resolution processes to resolve the fair hearing decisions. DHS can then issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws. If the matter goes to hearing, the hearings are conducted by an Administrative Law Judge employed by the Office of Administrative Hearings and the Department of Human Service participates in the hearing in coordination with OHA. The Department of Human Services has final order authority over MAGI eligibility, non-MAGI eligibility and HCBS benefits, and state plan personal care services fair hearings in these cases after the ALJ makes findings and may issue a final order. OHA retains final order authority over all other fair hearings. The Oregon Health Authority employees review the medical, dental, mental health/substance use services hearing requests.

Waiver - Office of Administrative Hearings (OAH)

1. Name of state agency to which responsibility is delegated: Office of Administrative Hearings (OAH)
2. Date waiver granted: 3/23/15
3. The type of responsibility delegated is (check all that apply):
 - a. Conducting fair hearings
 - b. Other
4. The scope of the delegation (i.e. all fair hearings) includes:

Office of Administrative hearings:

In 1999, the Oregon Legislature created the Office of Administrative Hearings (OAH) within the Department of Employment. The Office of Administrative Hearing is an independent state agency that conducts benefit and eligibility hearings for the Oregon Health Authority and resolves both Medicaid and non-Medicaid disputes. The Office of Administrative Hearing has approximately 65 Administrative Law Judges (ALJs) that serve approximately 70 state agencies. There is no

Intergovernmental Agreement (IGA) with the Office of Administrative Hearing because the relationship is mandated by Oregon Revised Statute, ORS 183.605 through 183.690.

Administrative law judges assigned from the OAH may conduct contested case proceedings on behalf of agencies as provided by ORS 183.605 to 183.690; Perform other services, that are appropriate for the resolution of disputes arising out of the conduct of agency business. All administrative law judges

in OAH must meet the standards and training requirements of ORS 183.680.

Office of Administrative Hearings (OAH)(Cont)

If a matter goes to hearing, the hearing is conducted by an Administrative Law Judge (ALJ), employed by OAH. The ALJ receives evidence, hears arguments and issues the initial order (which resolves the matter and becomes Final, absent intervention by the Oregon Health Authority. Should Oregon Health Authority disagree with the Office of Administrative Hearings, the Oregon Health Authority may review the application/interpretation of laws, rules, and policies. If merited, the Oregon Health Authority can change them. However, the OAH/ALJ findings of fact may only be changed by an ALJ at OAH. Under state law, it is the Office of Administrative Hearings that "conducts" these hearings and Oregon Health Authority participates.

Oregon Health Authority retains final authority over all eligibility and benefit fair hearings heard and decided by Office of Administrative Hearings. Oregon Health Authority retains oversight over the State Plan; the development and issuance of policies, rules and regulations on program matters; and the appeals process, including the quality and accuracy of the final decisions rendered by the Office of Administrative Hearings.

5. Methods for coordinating responsibilities between the agencies include:

- a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.
- b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.
- c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.
- d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.
- e. The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:
 - i. A written agreement between the agencies.
 - ii. State statutory and/or regulatory provisions.

Statutory/regulatory citation(s):

ORS 183.605 through 183.690

Office of Administrative Hearings (OAH)(Cont)

6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.

Yes

No

The Medicaid agency only reviews fair hearing decisions issued by the delegated entity with respect to the proper application of federal and state law regulations and policies. The review process is conducted by an impartial official not involved in the initial determination.

7. Additional methods for coordinating responsibilities among the agencies(optional):

There is extensive coordination for eligibility and appeals (MAGI and non-MAGI) as well as services-related appeals (benefits) among the Oregon Health Authority, and The Office of Administrative Hearings. Hearing request can come through OHA or DHS (no door is the wrong door). When a request comes into DHS or OHA the Office of Administrative Hearings is notified. Once OAH is notified their responsibilities include: scheduling the hearings, notifications to claimants and OHA/DHS staff about these hearings, communicating orders to claimants and DHS/OHA, retaining hearing files, and tracking data about the hearings. Initial eligibility appeal hearings request are assigned to DHS and medical or dental service level appeal hearing request are assigned to OHA. The Oregon Health Authority employees review the medical or dental service level hearing request and DHS employees review the eligibility hearing request, conduct the informal conference, and can issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws.

If the matter goes to hearing, the hearings are conducted by an Administrative Law Judge employed by the Office of Administrative Hearings, Oregon Health Authority participates in the hearing. Oregon Health Authority retains ultimate final order authority over all eligibility and benefit fair hearings in these cases after the ALJ makes findings and issues an order.

Section 8.4 Organization of agency

Transmittal 18-0007

Eligibility Determinations and Fair Hearings

42 CFR 431.10

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- a. The Medicaid agency
- b. Delegated governmental agency
 - i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
 - ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
 - iii. Other

2. The entity or entities that conduct determinations of eligibility based on age, blindness, and disability are:

- a. The Medicaid agency
- b. Delegated governmental agency
 - i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
 - ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
 - iii. The Social Security Administration determines Medicaid eligibility for SSI beneficiaries
 - iv. Other

3. Assurances:

- a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

42 CFR 431.10

B. Fair Hearings (including any delegations)

- The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E
- The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

- a. Medicaid agency
- b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.
- c. Local governmental entities
- d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

- All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver

C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- Yes
- No

A. Additional information (optional)

Organization and Administration
42 CFR 431.10
42CFR 431.11

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- a. A stand-alone agency, separate from every other state agency
- b. Also the Title IV-A (TANF) agency
- c. Also the state health department
- d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

Pursuant to Oregon State Law, and as permitted by Medicaid law, the Oregon Health Authority and the Department of Human Services have established an agreement regarding the provision of eligibility determination for the Medicaid program. The Oregon Health Authority will establish and implement eligibility policy and procedures across both the Oregon Health Authority and the Department of Human Services Medicaid/CHIP programs consistent with federal statutes

and regulations. The agreement defines the roles and responsibilities of the Oregon Health Authority, The Single State Agency, as the administrator of the Medicaid State Plan and the Department of Human Services, Title IV-A Agency, as an eligibility determination agency for the Medicaid program. The Department of Human Services determines eligibility for the MAGI and non-MAGI populations which includes families, adults, individuals under 21, Aged, Blind and disabled, Child Welfare, Foster children and Adoption Assistance, and family planning.

b. Fair Hearings (including expedited fair hearings)

Fair hearings are delegated per the Intergovernmental Cooperation Act of 1968 waiver. The delegated entities include:

The Office of Administrative hearings. In 1999, the Oregon Legislature created the Office of Administrative Hearings (OAH) within the Department of Employment. The Office of Administrative Hearing is an independent state agency that conducts benefit and eligibility hearings for the Oregon Health Authority and resolves both Medicaid and non-Medicaid disputes. The Office of Administrative Hearing has approximately 65 Administrative Law Judges (ALJs) that serve approximately 70 state agencies.

Organization and Administration
42 CFR 431.10
42 CFR 431.11

b. Fair Hearings (including expedited fair hearings) Cont.

There is no Intergovernmental Agreement (IGA) with the Office of Administrative Hearing because the relationship is mandated by Oregon Revised Statute, ORS 183.605 through 183.690. Administrative law judges assigned from the OAH may conduct contested case proceedings on behalf of agencies as provided by ORS 183.605 to 183.690; Perform other services, that are appropriate for the resolution of disputes arising out of the conduct of agency business. All administrative law judges in OAH must meet the standards and training requirements of ORS 183.680. Oregon Health Authority retains final authority over all eligibility and benefit fair hearings heard and decided by Office of Administrative Hearings. Oregon Health Authority retains oversight over the State Plan; the development and issuance of policies, rules and regulations on program matters; and the appeals process, including the quality and accuracy of the final decisions rendered by the Office of Administrative Hearings.

Department of Human Services:

The Oregon Health Authority (OHA) delegates the authority to use informal resolution processes to resolve fair hearings and the authority to review and issue final fair hearing decisions following the initial decision made by an Administrative Law Judge (ALJ) for the cases for which DHS has authority. DHS has authority over fair hearing requests related to eligibility for both MAGI and non-MAGI populations as well as hearings related to Title XIX Home and Community-Based services (HCBS) administered by DHS through approved 1915(c) waivers, 1915(j) and 1915(k) state plan options. DHS also has authority over fair hearing requests related to state plan personal care services operated by DHS, Aging and People with Disabilities and Office of Developmental Disabilities Services. DHS staff can perform the review of the hearing request and use informal resolution processes to resolve fair hearing requests. DHS staff may also issue dismissal orders for fair hearing requests for which DHS has authority. Should the Oregon Health Authority or the Department of Human Services disagree with the decision of the Office of Administrative Hearings, the Oregon Health Authority or the Department of Human Services may review the fair hearing decision for proper application/interpretation of laws, rules, and policies. If the Oregon Health Authority or the Department of Human Services finds that law, rules or policies have been improperly applied, DHS can change OAH's initial decision. However, the OAH/ALJ findings of fact may only be changed by an ALJ at OAH.

Organization and Administration	
42 CFR 431.10	42 CFR 431.11

b. Fair Hearings: DHS (Cont)

Under state law, it is the Office of Administrative Hearings that "conducts" these hearings and Department of Human Services and Oregon Health Authority participates.

The Oregon Health Authority, Office of Client and Community Services may review the eligibility fair hearing decision and propose changes, and the Department of Human Services has final order authority over MAGI eligibility, non-MAGI eligibility and HCBS benefit fair hearings decisions.

The Oregon Health Authority is responsible for the medical service hearings for Medicaid Members. This includes processing and tracking the requests and representing the state as lay representatives at the hearings.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

OHA utilizes both enrollment in Managed care organizations, known as Coordinated Care Organizations and fee-For-Services delivery systems. OHA comply' s with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services. The managed care delivery system is authorized under an 1115 demonstration waiver. The FFS program operates under an 1115 waiver

demonstration as well as 1902(a) state plan coverage. Once determined eligible, an individual will be in FFS for a period of time. The majority of these individuals will be enrolled in a CCO within 2 weeks of determination. Populations that are not enrollable into a CCO would receive services through this FFS option such as Citizen/Alien-Waived Emergency Medical (CAWEM). Services that are not included in CCOs and reimbursed under FFS for those enrolled in CCOs include items

such as: Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents, Hospice services for Members who reside in a skilled Nursing Facility, Long term care services and Therapeutic abortions (abortions comport with the Hyde amendment).

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Health Systems Division: has sub units that are made up of: Medicaid; Behavioral Health; Quality and compliance; Business Operations and Business Information. Health Systems Division includes the Medicaid Director who oversees integrated eligibility policy; Quality Assurance and Hearings; Provider services; Physical, Oral & Tribal Health programs. Hearings unit in HSD are responsible for the medical benefit service hearings for OHP Members.

Organization and Administration

42 CFR 431.10, 42 CFR 431.11

d. Program and policy support including state plan, waivers, and demonstrations (Cont)

These are hearings when a client is denied a prior authorization for a medical or surgical service as opposed to eligibility hearings. This includes processing and tracking the requests, and representing the state as lay representatives at the hearings. Quality Assurance unit Administers the External Quality Review Organization's (EQRO) contract and associated external quality review activities associated with the MCE's. Medicaid develops and implements policies for physical health care, dental health care. This section's functions include fee-for-service (FFS) & Coordinated Care Organization (CCO) administrative rules and contracts; federal regulations; state plan and waiver management; monitoring programs; Medicare coordination and CCO Delivery system management, including financial solvency and Tribal contracting. Behavioral Health is also a part of Health Systems Division and includes activities related to addiction & prevention, housing, licensing and credentialing. Some Behavioral Health activities are Medicaid and some are not.

Other OHA agency units that are considered 'shared services' and may support some of the Medicaid operations but are not exclusive to Medicaid are:

The Health Policy & Analytics Division: Activities include Health policy development for the provision of health care including publicly funded medical care and medical assistance. Other activities include policy analysis, research, and evaluation; Clinical Services Improvement oversees Quality Improvement, the Health Evidence Review Commission, the Pharmacy & Therapeutics Committee, and the Transformation Center. Health Information Technology manages the Medicaid

EHR incentive program and other statewide HIT initiatives. Health Analytics- includes the management of metrics for Medicaid programs, collection and analysis of data and provide technical assistance to support health system reform. Public Benefit plans- This is non Medicaid benefit plans. This subunit designs, contracts and administers a program of benefits for the state as the employer and state employees. The benefits include medical and dental coverage; life, accident, disability and long term care insurance; and flexible spending accounts.

e. Administration, including budget, legal counsel

Fiscal and Operations Division: Responsibilities include operational aspects that support the Medicaid agency for such things as staff training, human resources, administrative budget, program budget, facility settlements, Health Care Finance, cost allocation, audits, accounting, legal coordination, Actuarial services and building management. Many of these are shared services with the Department of Human Services (DHS).

Organization and Administration

42 CFR 431.10, 42 CFR 431.11

f. Financial management, including processing of provider claims and other health care financing

Business operations and Information systems responsibilities include operational functions of the MMIS subsystems, claims managements functions, provider screening and monitoring and CCO encounter data processing.

g. Systems administration, including MMIS, eligibility systems

System admin and MMIS are included above under Business operations noted above. Oregon Health Authority has Intergovernmental Agreements (IGAs) in place with the Department of Human Services, whose responsibilities include administrative or operational functions, specific to eligibility determinations and functions specific to the ONE eligibility system. DHS determines eligibility for the following MAGI and non-MAGI Medicaid populations: families, adults and in individuals under 21, Aged, Blind and Disabled, Child Welfare, Foster children and Adoption Assistance.

h. Other functions, e.g., TPL, utilization management (optional)

External Relations: The External Relations Division functions as the unit that connects together the seven agencies of the Oregon Health Authority. Provides communications to audiences both inside and outside OHA agency. Stakeholders includes Oregon legislators, Oregon Health Plan providers and members, advocates and community partners, local and federal government, public health, members of the media, and all Oregonians and their families. OPAR: Consists of various financial recovery areas such as estate recovery, Health Insurance group (TPR), Overpayment recovery, etc

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created
18-0007 Org chart	10/25/2018 12:44 PM EDT

B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency Title

Single state agency under Title IV-A (TANF)

Description of the functions the delegated entity performs in carrying out its responsibilities:

Eligibility Determinations Pursuant to Oregon State Law, and as permitted by Medicaid law, the Oregon Health Authority and the Department of Human Services have established an agreement regarding the provision of eligibility determination for the Medicaid program.

Organization and Administration

42 CFR 431.10, 42 CFR 431.11

Description of the functions the delegated entity performs in carrying out its responsibilities (Cont):

The Oregon Health Authority will establish and implement eligibility policy and procedures across both the Oregon Health Authority and the Department of Human Services Medicaid/CHIP programs consistent with federal statutes and regulations. The agreement defines the roles and responsibilities of the Oregon Health Authority, The Single State Agency, as the administrator of the Medicaid State Plan and the Department of Human Services, Title IV-A Agency, as an eligibility determination agency for the Medicaid program. The Department of Human Services determines eligibility for the MAGI and non-MAGI populations which includes families, adults, individuals under 21, Aged, Blind and disabled, Child Welfare, Foster children and Adoption Assistance.

E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):

Yes
 No

Description of the Medicaid functions or activities conducted or coordinated with another executive agency:

The Department of Human Services (DHS): includes functions and support for eligibility determination as referenced under the program description above. DHS is responsible for the delivery and administration of programs and services relating to: Children and families, including but not limited to child protective services, foster care, residential care for children and adoption services;

Elderly persons and persons with disabilities, including but not limited to social, health and protective services and promotion of hiring of otherwise qualified persons who are certifiably disabled; Persons who, as a result of the person's or the person's family's economic, social or health condition, require financial assistance or other social services; Developmental disabilities;

Vocational rehabilitation for individuals with disabilities;

Organization and Administration

42 CFR 431.10, 42 CFR 431.11

Description of the Medicaid functions or activities conducted or coordinated with another executive agency (Cont):

Licensing and regulation of individuals, facilities, institutions and programs providing health and human services and long term care services delegated to the department by or in accordance with the provisions of state and federal law; Services provided in long term care facilities, homebased and community-based care settings and residential facilities to individuals with physical disabilities or developmental disabilities and to seniors who receive residential facility care; and All other human service programs and functions delegated to the department by or in accordance with the provisions of state and federal law.

F. Additional information (optional)**Single State Agency Assurances**

42 CFR 431.10

42 CFR 431.12

42 CFR 431.50

A. Assurances

- 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- 2. All requirements of 42 CFR 431.10 are met.
- 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of subprofessional staff and volunteers.

B. Additional information (optional)

TN No. 18-0007

Approval Date: 1/15/19

Effective Date: 10/1/18

Supersedes TN No.17-0005

Section 8.4 Organization and Administration

Transmittal 17-0005

State Plan Administration Organization and Administration	A2
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42 CFR 431.10, 42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Oregon Health Authority

The Seventy-Fifth Oregon Legislative Assembly passed House Bill 2009, which was signed into law by the Governor in June of 2009, creating the Oregon Health Authority (OHA). The OHA is designated as the state Medicaid agency for the administration of funds from Title XIX of the Social Security Act. Legal authority for OHA to administer Medicaid is found in Oregon Revised Statute chapter 413. OHA is overseen by a nine-member, citizen-lead board called the Oregon Health Policy Board (OHPB). Members are appointed by the Governor and confirmed by the Senate. OHA performs oversight of all health related areas: Public Health; Oregon Educators’ Benefit Board (OEBC); Public Employees’ Benefit Board (PEBB); Oregon Prescription Drug Program (OPDP); Office for Health Policy and Research (OHPR); Addictions and Mental Health ; Health Analytics; Health Licensing Office (HLO); and Clinical Services Improvement.

As the Single State Agency, OHA has final authority over Medicaid programs and has the power to exercise administrative discretion in the administration and supervision of the Medicaid State Plan. The Medicaid Director is a cabinet-level position that reports to the Health Policy and Analytics Director of Oregon Health Authority. The OHA Director has oversight for all aspects of the Medicaid administration that includes the following units and their functions:

The Health Policy & Analytics Division: has five sub units, the sub units are made up of:

Health Policy- this is also broken into two subunits. Medicaid policy development and Clinical Improvement Services. Medicaid policy development includes developing the policies for and the provision of publicly funded medical care and medical assistance, including develop health policy for physical health care, oral health care and behavioral health care, eligibility policy, policy analysis, research, and evaluation; State plan and waiver administration. Clinical Improvement Services oversees Quality Improvement, the Health Evidence Review Commission, the Pharmacy & Therapeutics Committee, and the Transformation Center.

Public Benefit plans- This is non Medicaid benefit plans. This subunit designs, contracts and administers a program of benefits for the state as the employer and state employees. The benefits include medical and dental coverage; life, accident, disability and longterm care insurance; and flexible spending accounts.

Section 8.4 Organization and Administration

Transmittal 17-0005

Health Information Technology- manages the Medicaid EHR incentive program and other statewide HIT initiatives.

Health Analytics- includes the management of metrics for Medicaid programs, collection and analysis of data and provide technical assistance to support health system reform.

Business supports manages facilities, administrative staff.

Health Systems Division: has five sub units, the sub units are made up of: Quality and compliance; Providers services; compliance regulations; operations support and business systems support. These five units are responsible to oversee eligibility quality and compliance; implement policies and monitor programs for physical health care, dental health care and mental health and substance use disorders; operational aspects for both fee-for-service (FFS) & Coordinated Care Organization (CCO) such as administrative rules; contracts; medical program hearings and coordination with DHS application processing centers and branches; clinical claims review, administrative claim appeals, transplant & out-of-state services coordination, CCO quality assurance and MMIS operations and maintenance.

Fiscal and Operations Division: Responsibilities include operational aspects that support the Medicaid agency for such things as staff training, human resources, administrative budget, program budget, facility settlements, Health Care Finance, cost allocation, audits, accounting, legal coordination and building management. Many of these are shared services with the Department of Human Services (DHS).

Oregon Health Authority has Intergovernmental Agreements (IGAs) in place with the Department of Human Services, whose responsibilities include administrative or operational functions, including eligibility determinations as necessary and appropriate for the following MAGI and non-MAGI Medicaid populations: families, adults and in individuals under 21, Aged, Blind and Disabled, Child Welfare, Foster children and Adoption Assistance.

Oregon Health Authority determines eligibility for the Family Planning waiver population that are not full benefit Medicaid eligible

Upload an organizational chart of the Medicaid agency.

Attachment submitted

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

Section 8.4 Organization and Administration

Transmittal 17-0005

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Oregon Health Authority (OHA) is overseen by a nine-member, citizen-lead board called the Oregon Health Policy Board (OHPB). Members are appointed by the Governor and confirmed by the Senate. OHA performs oversight of all health related divisions: Public Health; Health Systems; Health Policy & Analytics; State Hospital; External Affairs, Office of Equity and Inclusion, and Chief Financial Officer/Chief Operating Officer.

As the Single State Agency, the Oregon Health Authority has final authority over Medicaid programs and has the power to exercise administrative discretion in the administration and supervision of the Medicaid State Plans. Other agencies, not part of the Oregon Health Authority, that interact with or coordinate Medicaid funds or administration are: The Department of Human Services (DHS):

includes functions and support for eligibility determination as referenced under the program description above. DHS is responsible for the delivery and administration of programs and services relating to: Children and families, including but not limited to child protective services, foster care, residential care for children and adoption services; Elderly persons and persons with disabilities, including but not limited to social, health and protective services and promotion of hiring of otherwise qualified persons who are certifiably disabled; Persons who, as a result of the person's or the person's family's economic, social or health condition, require financial assistance or other social services; Developmental disabilities; Vocational rehabilitation for individuals with disabilities; Licensing and regulation of individuals, facilities, institutions and programs providing health and human services and long term care services delegated to the department by or in accordance with the provisions of state and federal law; Services provided in long term care facilities, home-based and community-based care settings and residential facilities to individuals with physical disabilities or developmental disabilities and to seniors who receive residential facility care; and All other human service programs and functions delegated to the department by or in accordance with the provisions of state and federal law.

Office of Administrative Hearings (OAH): In 1999, the Oregon Legislature created the Office of Administrative Hearings within the Department of Employment. OAH is an independent state agency that conducts medical and eligibility hearings for Medicaid and resolves other non-Medicaid disputes. OAH has approximately 65 Administrative Law Judges (ALJs) that serve approximately 70 state agencies.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Eligibility Determinations

Pursuant to Oregon State Law, and as permitted by Medicaid law, the Oregon Health Authority and the Department of Human Services have established an agreement regarding the provision of eligibility determination for the Medicaid program. The Oregon Health Authority will establish and implement eligibility policy and procedures across both the Oregon Health Authority and the Department of Human Services Medicaid/CHIP programs consistent with federal statutes and regulations, Both Oregon Health Authority and the Department of Human Services may have eligibility determination responsibilities. The agreement defines the roles and responsibilities of the Oregon Health Authority, The Single State Agency, as the administrator of the Medicaid State Plan and the Department of Human Services, Title IV-A Agency, as an eligibility determination agency for the Medicaid program.

The Department of Human Services determines eligibility for the non-MAGI populations of the Aged, Blind and disabled, Child Welfare, Foster children and Adoption Assistance. Individuals may access a single streamlined application process either through the state exchange web portal or directly through a branch office.

State Plan Administration	
Assurances	A3
42 CFR 431.10, 42 CFR 431.12, 42 CFR 431.50	
<p>Assurances</p> <p><input checked="" type="checkbox"/> The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.</p> <p><input checked="" type="checkbox"/> All requirements of 42 CFR 431.10 are met.</p> <p><input checked="" type="checkbox"/> There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.</p> <p><input checked="" type="checkbox"/> The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.</p> <p>Assurance for states that have delegated authority to determine eligibility:</p> <p><input checked="" type="checkbox"/> There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).</p> <p>Assurances for states that have delegated authority to conduct fair hearings:</p> <p><input type="checkbox"/> There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).</p> <p><input type="checkbox"/> When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.</p> <p>Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:</p> <p><input checked="" type="checkbox"/> The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.</p>	

Section 8.5 Non-Financial Eligibility-Residency

Transmittal 13-0016

State Residency	S88
42 CFR 435.403	
State Residency	
<input checked="" type="checkbox"/> The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.	
Individuals are considered to be residents of the state under the following conditions:	
<input checked="" type="checkbox"/> Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:	
<input checked="" type="checkbox"/> Intends to reside in the state, including without a fixed address, or	
<input checked="" type="checkbox"/> Entered the state with a job commitment or seeking employment, whether or not currently employed.	
<input checked="" type="checkbox"/> Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.	
<input checked="" type="checkbox"/> Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:	
<input checked="" type="checkbox"/> Residing in the state, with or without a fixed address, or	
<input checked="" type="checkbox"/> The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.	
<input checked="" type="checkbox"/> Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:	
<input checked="" type="checkbox"/> Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or	
<input checked="" type="checkbox"/> Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or	
<input checked="" type="checkbox"/> If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.	
<input checked="" type="checkbox"/> Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.	
<input checked="" type="checkbox"/> Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.	
<input checked="" type="checkbox"/> Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.	
<input checked="" type="checkbox"/> IV-E eligible children living in the state, or	
<input checked="" type="checkbox"/> Otherwise meet the requirements of 42 CFR 435.403.	

Section 8.5 Non-Financial Eligibility-Residency

Transmittal 13-0016

Meet the criteria specified in an interstate agreement.

Yes No

The state has interstate agreements with the following selected states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input checked="" type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input checked="" type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input checked="" type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input checked="" type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
- Are in the state only for the purpose of attending school
- Are out of the state only for the purpose of attending school
- Retain addresses in both states
- Other type of individual

Name of Type	Description
Nom IV-E placements	As applicable under the ICAMA agreement

The state has a policy related to individuals in the state only to attend school.

Yes No

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school.

Yes No

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

8.6 Non-Financial Eligibility-Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens who meet all other Medicaid eligibility requirements under the state plan consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

A. Citizens, Nationals and Eligible Non-Citizens

The state provides Medicaid to otherwise eligible individuals:

1. Who are citizens or nationals of the United States; or
2. Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 USC 1641) or who are non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility, subject to the requirements at 8 USC 1621(b)(2), and are not restricted by section 403 of PRWORA (8 USC 1613); or who are non-citizens whose eligibility is required by 9 USC 1612(b)(2)€ and (F); and
3. Who have declared themselves to be citizens or nationals of the United States, or non-citizens having satisfactory immigration status during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, 911, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

- a. The agency provides for an extension of the reasonable opportunity period for non-citizens if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

Yes No

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

- b. When a reasonable opportunity is provided, the agency furnishes benefits to otherwise eligible individuals on the following date:

The date benefits are furnished is:

- i. The date of application containing the declaration of citizenship or immigration status;
 ii. The first day of the month of application

B. Optional Coverage of Qualified Non-Citizens

The state provides Medicaid coverage to all otherwise eligible qualified Non-Citizens whose eligibility is not restricted by section 403 of PRWORA (8 U.S.C 1613)

Yes No

C. Coverage of Lawfully Residing Individuals

The state elects the option to provide Medicaid coverage to otherwise eligible individuals lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

Yes No

1. Pregnant women

2. Individuals under a specified age:

- a. Individuals under age 21
 b. Individuals under age 20
 c. Individuals under age 19

3. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

4. An individual is considered to be lawfully present in the United States if he or she:

a. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

b. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

c. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

d. A non-citizen who belongs to one of the following classes:

i. Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

ii. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

iii. Granted employment authorization under 8 CFR 274a.12(c);

iv. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

v. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

vi. Granted Deferred Action status;

vii. Granted an administrative stay of removal under 8 CFR 241;

viii. Beneficiary of approved visa petition who has a pending application for adjustment of status;

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who:

i. Has been granted employment authorization; or

ii. Is under the age of 14 and has had an application pending for at least 180 days;

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Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

- f. Has been granted withholding of removal under the Convention Against Torture;
- g. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
- h. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
- i. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
- j. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (a) through (i) of this definition.
- k. Other

D. Emergency Coverage

The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

1. Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;
2. Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

E. Additional Information (optional)

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PRESUMPTIVE ELIGIBILITY BY HOSPITALS

The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.
2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.
3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

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PRESUMPTIVE ELIGIBILITY BY HOSPITALS

B. Eligibility Groups or Populations Included

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

Yes No

9. Other Medicaid state plan eligibility groups:

10. Demonstration populations covered under section 1115

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PRESUMPTIVE ELIGIBILITY BY HOSPITALS

C. Standards for Participating Hospitals

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

Yes No

The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

FPL

90.00%

D. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.

2. The end date of the presumptive period is the earlier of:

- The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
- The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

a. No more than one period within a calendar year.

b. No more than one period within two calendar years.

c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

e. Other reasonable limitation:

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 PRESUMPTIVE ELIGIBILITY BY HOSPITALS

E. Application for Presumptive Eligibility

1. The state uses a standardized screening process for determining presumptive eligibility.
2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.
3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Name	Date Created
he7260-0518	5/14/2018 9:52 AM EDT

4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
2. Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

- a. A reasonable estimate of MAGI-based income is used to determine household income.
- b. Gross income is used to determine household size.
- c. Other income methodology
3. State residency
4. Citizenship, status as a national, or satisfactory immigration status

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PRESUMPTIVE ELIGIBILITY BY HOSPITALS

G. Qualified Entity Requirements

1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.

2. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created
HPE Provider Training Overview The Hospitals Role	2/20/2018 12:59 PM EST
HPE Provider Training Reporting Requirements	2/20/2018 12:59 PM EST
Making Determinations-0518	5/14/2018 9:45 AM EDT

H. Additional Information (optional)

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8.8 COST SHARING

Cost Sharin Requirement	G1
1916 1916A 42 CFR 447.50 through 447.57(excluding 447.55)	
The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

TN No. 16-0010
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