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

Oregon Health Authority
State of Oregon

HCFA-AT-80-38 (BPP)
July 12, 2016

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Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S57, and S14 and related pages or sections of pages being deleted as obsolete.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	

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Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S57, and S14 and related pages or sections of pages being deleted as obsolete.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	

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: OR-13-0013-MM2	**STATE:** Oregon
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN 91-25 Effective date: 1/1/91, approved: 1/23/92 Section 2, Page 11a,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

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.	

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.	

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 *(If Applicable)*:** Notwithstanding any other provisions of the Oregon Medicaid State Plan, the financial eligibility methodologies described in State 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.

SUPERSEDING PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: OR-13-0015-MM	**STATE:** Oregon	
PAGE NUMBER OG THE PLAN SECTION OR ATTACHMENT: A1-A3	**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 General certification) Attachment 1.2-A (Organizational chart) Attachment 1.2-B (Description of the functions of the single state agency) Attachment 1.2-C (Description of professional medical and supporting staff) Attachment 1.2-D	**PARTIAL PAGES SUPERSEDED:** Section 1.4 (page 9)(State Medical Care Advisory Committee only. Tribal consultation will remain in the state plan.)

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PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S88 – Non-Financial Eligibility- State Residency	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, page 13, item 2.3, TN 87-12 Attachment 2.6-A: Page 3, Item 4, TN 02-08

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
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

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

State/Territory: OREGON

TABLE OF CONTENTS

SECTION PAGE NUMBERS

SECTION 1 - SINGLE STATE AGENCY ORGANIZATION ...

1.1-1.3 Replaced by Section 8...

1.4 Tribal Consultation Policy ……..... 9

SECTION PAGE NUMBERS

SECTION 2 - COVERAGE AND ELIGIBILITY…….. 10

**** MAGI elements included in Section 8*******

2.1 Application, Determination of Eligibility and Furnishing Medicaid 10

2.2 Coverage and Conditions of Eligibility 12
(MAGI elements included in Section 8)

2.3 Residence 13

2.4 Blindness 14

2.5 Disability 15

2.6 Financial Eligibility 16

2.7 Medicaid Furnished Out of State 18

SECTION PAGE NUMBERS

SECTION 3 - SERVICES: GENERAL PROVISIONS 19

3.1 Amount, Duration, and Scope of Services 19

3.2 Coordination of Medicaid with Medicare Part B 29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases 30

3.4 Special Requirements Applicable to Sterilization Procedures 31

3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries 31a

3.6 Ambulatory Prenatal Care for Pregnant Women during Presumptive Eligibility Period 31b

	SECTION	PAGE NUMBERS
SECTION 4 - GENERAL PROGRAM ADMINISTRATION		32
4.1	Methods of Administration	32
4.2	Hearings for Applicants and Recipients	33
4.3	Safeguarding Information on Applicants and Recipients	34
4.4	Medicaid Quality Control	35
4.5	Medicaid Agency Fraud Detection and Investigation Program	36
4.6	Reports	37
4.7	Maintenance of Records	38
4.8	Availability of Agency Program Manuals	39
4.9	Reporting Provider Payments to the Internal Revenue Service	40
4.10	Free Choice of Providers	41
4.11	Relations with Standard-Setting and Survey Agencies	42
4.12	Consultation to Medical Facilities	44
4.13	Required Provider Agreement	45
4.14	Utilization Control	46
4.15	Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases	51
4.16	Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees	52
4.17	Liens and Recoveries	53
4.18	Cost Sharing and Similar Charges	54
4.19	Payment for Services	57

	SECTION	PAGE NUMBERS
4.20	Direct Payments to certain Recipients for Physicians' or Dentists' Services	67
4.21	Prohibition Against Reassignment of Provider Claims	68
4.22	Third Party Liability	69
4.23	Use of Contracts	71
4.24	Standards for Payments for Skilled Nursing and Intermediate Care Facility Services	72
4.25	Program for Licensing Administrators of Nursing Homes	73
4.26	RESERVED	74
4.27	Disclosure of Survey information and Provider or Contractor Evaluation	75
4.28	Appeals Process for Skilled Nursing and Intermediate Care Facilities	76
4.29	Conflict of Interest Provisions	77
4.30	Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals	78
4.31	Disclosure of Information by Providers and Fiscal Agents	79
4.32	Income and Eligibility Verification System	79
4.33	Medicaid Eligibility Cards for Homeless Individuals	79a
4.34	Systematic Alien Verification for Entitlements	79b
4.35	Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation	79c

SECTION PAGE NUMBERS

SECTION 5 - PERSONNEL ADMINISTRATION 80

5.1 Standards of Personnel Administration 80

5.2 RESERVED 81

5.3 Training Programs; Subprofessional and Volunteer Programs 82

SECTION PAGE NUMBERS

SECTION 6 - FINANCIAL ADMINISTRATION 83

6.1 Fiscal Policies and Accountability 83

6.2 Cost Allocation 84

6.3 State Financial Participation 85

SECTION PAGE NUMBERS

SECTION 7 - GENERAL PROVISIONS 86

7.1 Plan Amendments 86

7.2 Nondiscrimination 87

7.3 Maintenance of AFDC Effort 88

7.4 State Governor's Review 89

SECTION SPA NUMBERS

SECTION 8 – MAGI templates

8.1 MAGI based eligibility, Mandatory & Optional…… 13-0012
Parent and Caretakers-M
Pregnant Women-M
Infants and Children-M
Individuals below 133%-M
Former Foster Care-M
Reasonable Classification of Individuals-O
Non-IV-E Adoption-O
Foster Care-Chafee-O
AFDC income standards

8.2 Eligiblity process .....…… 13-0013
Appliction, renewals, enrollment

8.3 Magi income .....….. 13-0014
Pregnant woment counted, changes in income, cash support, full-time students

8.4 Single state agency .....…….. 13-0015
A1-Attorney General Certification
A1-Waivers under the Intergovernmental Cooperation Act
A2-Organization and Function of Medical Assistance Unit
A2-Organization and Function of State Agency
A2-Description of Staff making eligibility determination
A3-State Medicaid Advisory Committee

8.5 Residency .....….. 13-0016

8.2 Citizenship .....….. 13-0017

8.3 Hospital presumptive eligibility .....….. 13-0018

LIST OF ATTACHMENTS

No.	Title of Attachment
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

No.	Title of Attachment
* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
* Supplement 5a-	Methodologies for Treatment of Resources for Individuals with Incomes Up to a Percentage of the Federal Poverty Level
* Supplement 6 -	Standards for optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States -Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a-	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b-	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
* Supplement 9 -	Transfer of Resources
* Supplement 10-	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 11-	Cost-Effective Methods for COBRA Groups (States and Territories)
* Supplement 12-	Variations from the Basic Personal Needs Allowance
* Supplement 13-	Section 1924 Provisions
* Supplement 14-	Eligibility Conditions and Requirements

*2.6-A Eligibility Conditions and Requirements (Territories only)

* Supplement 1 -	Income Eligibility Levels - Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 3 -	Resource Levels for optional Groups with Incomes up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
	* Supplement 1 - Case Management Services
	Supplement 2 - Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
3.1-H	Health Homes for individuals with chronic conditions
3.1-K	Communitry First Choice Option
3.1-L	Alternative Benefit Plan

No.	Title of Attachment
4.10-A	Free Choice of Providers
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutionalized Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy – Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

\

No.	Title of Attachment
4.19-B	Methods and Standards for Establishing Payment Rates - Other Types of Care
	* Supplement 1 - Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates - Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claims Payment - Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability--Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability--Payment of Claims
*4.22-C	Cost-Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
7.2-A	Methods of Administration - Civil Rights (Title VI)
4.35-A	Criteria for the Application of Specified Remedies for Nursing Facilities.
4.35-B	Alternative Remedies to Specified Remedies for Nursing Facilities.

*Forms Provided

Revision:

No.	Supersede pages for ACA templates	Section
13-0012	Attachment 2.2-A Supplement 1 to Attachment 2.2-A Attachment 2.6-A Supplement 1 to Attachment 2.6-A Supplement 2 to Attachment 2.6-A Supplement 8a to Attachment 2.6-A Supplement 12 to Attachment 2.6-A Supplement 14 to Attachment 2.6-A	8.1

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)		
	Replaced by ACA TN No. 13-0015-Section 8	
~~42 CFR 431.12(b) AT-78-90~~	~~1.4~~	~~State Medical Care Advisory Committee~~ ~~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.

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)

Impacts that are considered to have direct affects on Native Americians, 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.

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.

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APRIL 1994

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

State/Territory: __OREGON_____

Citation(s)

1928 of the Act 1.5 Pediatric 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.

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APRIL 1994

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

State/Territory: __OREGON_____

Citation(s)

1928 of the Act 1.5 Pediatric Immunization Program

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)

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

State/Territory: __OREGON_____

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation(s)	
	Replaced by ACA TN No. 13-0013 in section 8
	~~2.1 Application, Determination of Eligibility and Furnishing Medicaid~~
~~42 CFR 435.10 and Subpart J~~	~~(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.~~

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 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan 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 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 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 1920 of the Act	___	(3)	Pregnant women are entitled to ambulatory prenatal care 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):
		X	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.
		X	A PIHP that meets the definition of 1903(m) of the Act and 42 CFR 438.2.
	P&I	X	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)		
Replaced by ACA TN No. 13-0013 in section 8		
~~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~~.

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:

The Supplemental Nutritional Assistance Program (SNAP) and selected Department of Education,
National School Lunch Program (NSLP).

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)

(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.

SNAP ELE Process:
Periodically, the state sends mailings to SNAP recipients in households containing children. The mailings invite caretakers to apply for children either through a phone call or by returning a short form. The state uses SNAP findings for income and eligibility group size for Medicaid and CHIP eligibility determinations for children who apply via these methods .. The state also uses SNAP findings for verification of SSN and state residency. The state then verifies citizenship and obtains any supplemental health insurance information.

SNAP Non-ELE Process:

The state uses MAGI-based income methodology as described in 42 CFR 435.603 to determine the household income and family size for MAGI-based Medicaid and MAGI-based CHIP medical eligibility determinations. SNAP does not use MAGI or MAGI-based income methodology. The state allows adjustments made to income based on IRS determination of Adjusted Gross Income in determining medical eligibility. SNAP does not allow the same adjustments. For example, the state excludes child support received by children in the household in determining medical eligibility, and SNAP includes it.

Citation(s)

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

(4) (Continued)

Filing groups differ between SNAP and Medicaid/CHIP. For SNAP, filing groups may include anyone living in the same home who purchases and prepares food together. For MAGI-based Medicaid/CHIP, the household is defined in 42 CFR 435.603(f) and is based on taxable income households, with certain exceptions allowed, as for example, individuals who do not file taxes.

THE NATIONAL SCHOOL LUNCH PROGRAM (NSLP) ELE Process:
The state sent mailings to households receiving NSLP in participating school districts. The mailings invited families to apply through a phone call or by returning a short form. For those who responded the state used NSLP findings for income, eligibility group size, and residency for Medicaid and CHIP eligibility determinations. The state then verified SSN and citizenship. The state also obtained any supplemental health insurance information.

NSLP Non-ELE Process:
The state uses MAGI-based income methodology as described in 42 CFR 435.603 to determine the household income and family size used for MAGI-based Medicaid and MAGI-based CHIP; NSLP did not.

The state allows adjustments made to income based on IRS determination of Adjusted Gross Income in determining medical eligibility. NSLP did not allow the same adjustments. For example, the state excludes child support received by children in the household in determining medical eligibility and NSLP included it.
For MAGI-based Medicaid/CHIP, the household is defined in 42 CFR 435.603(f) and is based on taxable income households, with certain exceptions allowed, as for example, individuals who do not file taxes. NSLP counts the income of all household members

Citation(s)

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

(4) (Continued)

The state uses monthly income or annual income as described in 42 CFR 435.603 NSLP used annual income unless it is not representative. In that case, the income is anticipated.

The state considers a child to live in the household where the child spends most nights or with the caretaker who has legal custody. NSLP allows children to receive benefits in both households in shared custody situations.

The state uses 42 CFR 435.603(f) to form MAGI-based Medicaid/CHIP eligibility groups based on relationships and tax status of household members. NSLP forms eligibility groups based on all household members regardless of their relationships.

The state accepts self-attestation for numerous eligibility items. NSLP verified information if it was questionable and verifies information for a statistical sample of applicants. If information is questionable, NSLP temporarily certified children and requires verification at a later time.

In some school districts, the entire school population is certified for NSLP regardless of income.

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) _30__ 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 equals 163% for all children; 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.

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) _30__ 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 equals 163% for all children; 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.

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

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.2 Coverage and Conditions of Eligibility

42 CFR 435.10

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.

X 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.

Revision: HCFA-PH-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

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

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)	
	Replaced by ACA TN No. 13-0016 in section 8
~~2.3~~	~~Residence~~
~~435.10 and 435.403, and 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 the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.~~

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.

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.

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.

Transmittal #86-33
Revision:HCFA-PM-86-20(BERC)
OMB-No. 0938-0193
SEPTEMBER 1986

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 1902(b) of the Act, P.L. 99-272 (Section 9529)	Medicaid is furnished under the conditions specified in 42 CFR 431.52 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.

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

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

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)			
	3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)		
1902(e)(5) of the Act		(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day 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.
	X	(iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
1902(a)(10) (F) (VII) of the matter following (E) of the Act		(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.

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)			
	3.1(a)(1)		Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(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) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

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

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)
1905(a)(26) and 1934		X	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.)

Transmittal #13-09
OMB No.: 0938-1024

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.

Transmittal #03-04
Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

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 42 CFR 440.220	(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care 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)(l) 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 the Act	(ii) Prenatal care and delivery services for pregnant women.

Transmittal #03-04
Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)			
	3.1(a)(2)		Amount, Duration, and Scope of Services: Medically Needy (Continued)
		(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 ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.
			XX 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,	___	(vii)	Services in an institution for mental diseases for individuals over age 65.
442.441, Subpart C	___	(viii)	Services in an intermediate care facility for the mentally retarded.
1902(a)(20) and (21) of the Act	___	(ix)	Inpatient psychiatric services for individuals under age 21.
1902(a)(10)(C)	___		

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

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)			
	3.1(a)(2)		Amount, Duration, and Scope of Services: Medically Needy (Continued)
1902(e)(9) of Act	____	(ix)	Respiratory care services are provided to ventilator dependent individuals as indicated in item3.1(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.)

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)
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10) (E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals 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)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries 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)	Other Required Special Groups Qualifying Individuals - 1 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.

Revision: HCFA-PM-98-1 (CMSO) Transmittal NO.. 98-10
April 1998

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		Amount, Duration and Scope of Services: (Continued)
1902(a) and 1903(v) of the Act, Sec. 401(b)(1)(A) of P.L.	(a)(6)	Limited Services for Certain Aliens: 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.
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.
		Presumably Eligible Pregnant Women
1902(a)(47) ___ and 1920 of the Act	(a)(8)	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.
42 CFR 441.55 50 F.R. 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Transmittal #91-25
Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

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) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence 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 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 that is eligible for payment under the State plan.
42 CFR 441.55 50 F.R. 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)		
	3.1 (a)(9)	Amount, Duration, and Scope of services: EPSDT Services (continued)
42 CFR 441.60	X	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)	Comparability of Services P&I 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:
1902(a) and 1902 (a)(10), 1902(a)(52) 1903(v), 1915(g), and 1925(b)(4) and 1932 the Act		(i) Services made available to the categorically needy of are equal in amount, duration, and scope for each categorically needy person.
		(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.
		(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
	X	(iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

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.
		X 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 2l or over; SNF services are provided
		___ Yes, to individuals under age 18; SNF services are provided
		___ No; SNF services are not provided
		X Not applicable; the medically needy are not included under this plan

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).

Transmittal #80-11

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.

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.

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)		
	3.1 (f) (1)	Optometric Services
42 CFR 441.30 AT-78-90		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. _ Yes. _ 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. X Not applicable. The conditions in the first sentence do not apply.
1903(i)(1) of the Act, P.L. 99-272 (Section 9507)	(2)	Organ Transplant Procedures Organ transplant procedures are provided. _ No. X 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 ATTACHMENT 3.1-E.

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)		
	3.1 (g)	Participation by Indian Health Service Facilities
42 CFR 431.110(b) AT-78-90		Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.
		Reimbursement for Indian Health Service and Tribal Health Facilities
		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 following providers are to be reimbursed under the IHS encounter rate: Physicians, Physician Assistants, Nurse Practitioners, Nurse Midwives, Dentists, Pharm D, or other health care professionals to provide: Medical, Diagnostic, Screening, Dental Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Management, Speech, Hearing, or Home Health Services.
		These services are not limited except as directed by the General Rules - Medical Assistance Benefits: Excluded Services and Limitations, the American Indian/Alaska Native Billing Guide and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows: Coverage for diagnostic services and treatment for those services funded on the HSC List and Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HSC List.
		Drugs/Biologicals and Medical Transportation services are outside the IHS encounter rate and are reimbursed under the OMAP fee-for-service system.
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;

Transmittal #07-05
OMB No.: 0938-0193

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

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

(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.

X 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)

3.2 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

X Buy-In agreement for:

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

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).

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

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)	
	(b) Deductible/Coinsurance
	(1) Medicare Part A and B
1902(a)(30), 1902(n), 1905(a), and 1916 of the Act	Supplement 1 to ATTACHMENT 4.19-B 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) Qualified Medicare Beneficiaries (QMBs) 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) Other Medicaid Recipients 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) Dual Eligible--QMB plus 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).

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.

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)

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

42 CFR 441.l0l,
42 CFR 431.620(c)
and (d)
AT-79-29

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)		
	3.4	Special Requirements Applicable to Sterilization Procedures
42 CFR 441.252 AT-78-99		All requirements of 42 CFR Part 441, Subpart F are met.

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 Families Receiving Extended Medicaid Benefits

(a) 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 ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second-month period of 6-month extended Medicaid benefits under section 1925 of the Act are--

X Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

__ 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:

__ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__ Medical or remedial care provided by licensed practitioners.

___ Home health services.

Transmittal #91-25
Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
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.

Transmittal #91-25
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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)

(c) X 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--

X 1st 6 months X 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).

Transmittal #91-25
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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)

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).

Transmittal #87-19
Revision: HCFA-PM-87- 4 (BERC) OMB No.: 0938-0193
MARCH 1987

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	4.1 Methods of Administration
42 CFR 431.15 AT-79-29	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.

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.

Transmittal #87-40
Revision: HCFA--AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

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.

Transmittal #87-19
Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

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.

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

Transmittal #88-26
Revision: HCFA-PM-88-10 (BERC) MB No.: 0938-0193
SEPTEMBER 1988

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 48 FR 3742, 52 FR 48817	The Medicaid agency has established and will maintain methods, criteria 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.

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.

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	4.5 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 preparing a RFP to seek bids for a Medicaid RAC and expects to enter into a contract before April 1, 2011." 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. ☐ 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 equivalent to that published rate.

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

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	4.5 Medicaid Recovery Audit Contractor program (Cont)
	☐ 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.
Section 1902(a)(42)(B)(ii)(II)(bb) Of the Act	☒ 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)(III) of the Act	☒ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902(a)(42)(B)(ii)(IV)(aa) of The Act	☒ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(b)(ii)(IV)(bb) of The Act	☒ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902(a)(42)(B)(ii)(IV)(cc) of The Act	☒ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Transmittal #80-11

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)	
	4.6 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.

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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)	
	4.7 Maintenance of Records
42 CFR 431.17 AT-79-29	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.

Transmittal #80-11

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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)		
	4.8	Availability of Agency Program Manuals
42 CFR 431.18(b) AT-79-29		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.

Transmittal #80-11

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)	
	4.9 Reporting Provider Payments to Internal Revenue Service
42 CFR 433.37 AT-78-90	There are procedures implemented in accordance with 42 CFR 433.37 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.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	4. 10 Free Choice of Providers
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)	(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. (b) Paragraph (a) does not apply to services furnished to an individual-- (1) Under an exception allowed under 42 CFR 431.54, Subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, (P&I)
Section 1902(a)(23) of the Social Security Act P.L. 105-33	(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. or
Section 1932(a)(1) Section 1905(t)	(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c). (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).

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	4.11 Relations with Standard-Setting and Survey Agencies
42 CFR 431.610 AT-78-90 AT-80-34	(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 sanitoria) that provide services to Medicaid recipients. This agency is The Oregon Health Authority.
	(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): The Oregon Health Authority.
	(c) ATTACHMENT 4.11-A 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.

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 CFR 431.610 AT-78-90 AT-89-34	4.11 (d)	The Department of Human Services (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.

Transmittal #80-11

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).

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

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

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

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.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

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 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. (b) Provide written information to all adult individuals on their policies concerning implementation of such rights; (c) 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

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

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: X Directly X 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)	X 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.

Transmittal #85-14
Revision: HCFA-PM-85-3 (BERC) OMB No. 0938-0193
MAY 1985

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.

X 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.

Transmittal #85-19
Revision: HCFA-PM-85-7 (BERC) OMB NO. 0938-0193
JULY 1985

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)	The Medicaid agency meets the requirements of42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

X 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 D for:

__ All mental hospitals.

__ Those specified in the waiver.

__ No waivers have been granted.

___ Not applicable. Inpatient services in mental hospitals are not provided under this plan

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

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.

42 CFR 456.2
50 FR 15312

X 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.

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.

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 42 CFR 438.356(b) and (d)	The State must ensure that an External Quality Review 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 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

X The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

__ ICFs/MR;

X Inpatient psychiatric facilities for recipients under age 21; and

X Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

__ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

__ 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.

__ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Transmittal #04-03

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. .

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

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).

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.

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.
	X	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)	X	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.

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.

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.

(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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: __OREGON_____

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	4.18 Recipient Cost Sharing and Similar Charges
42 CFR 447.51 through 447.58	(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act	(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:
	(1) No enrollment fee, premium, or similar charge is imposed under the plan.
	(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--
	_X_ Age 19
	____ Age 20
	____ Age 21
	Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.
	(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation(s)		
	4.18(b)(2) (Continued)	
42 CFR 447.51 through 447.58	(iii)	All services furnished to pregnant women. ___ 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 or her 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.
42 CFR 438.108 42 CFR 447.60	(vii)	Services furnished by a MCO, PIHP, PAHP or health insuring organization in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60. [X] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing. [ ] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.
1916 of the Act, P.L. 99-272, (Section 9505)	(viii)	Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.18 (b) (continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for 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 groups:

_____ 18 or older

___X__ 19 or older

_____ 20 or older

_____ 21 or older

___ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

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, ATTACHMENT4.18-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.

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 sections1925(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.

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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)

4.18(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 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.
		_____ 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.
		__X___ Not applicable. No such charges are imposed.

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

___X__ 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 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.

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)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections1902(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.

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Revision: HCFA-PM-93- 6 (MB) OMB No.: 0938-
August 1993

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 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	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: (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. ATTACHMENT 4.19-B 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). (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. ATTACHMENT 4.19-B 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.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Transmittal #80-11

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 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility. X Yes. The State's policy is described in ATTACHMENT 4.19-C. ___ No.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.19 (d)

42 CFR 447.252
47 FR 47964
48 F. 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

X (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.

X 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.

X 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.

Transmittal #80-11

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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 447.45(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.

Transmittal #87-19
Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19(f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. 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.

Transmittal #80-11

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.

Transmittal #80-11

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

Transmittal #80-11

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

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)			
42 CFR 447.201 and 447.205	4.19	(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act		(k)	The Medicaid agency meets the requirements of section 1903(v) of 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.

Transmittal #92-19

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.

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 in1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

X 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 the Act

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

Transmittal #80-11

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	Direct Payments to Certain Recipients for Physicians' or Dentists' Services Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25. ___ Yes, for ___ physicians' services ___ dentists' services ATTACHMENT 4.20-A specifies the conditions under which such payments are made to recipients. X Not applicable. No direct payments are made to recipients.

TN No. 759-1

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.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

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.
1902(a)(25)(H) and (I) of the Act	(4) Sections 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;
42 CFR 433.138(g)(1)(ii) and (2)(ii)	(2) Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
42 CFR 433.138(g)(3)(i) and (iii)	(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
42 CFR 433.138(g)(4)(i) through (iii)	(4) Describes the methods the agency uses for following up on 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 babe and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

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)(ii)(A)	X	(c)		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)		ATTACHMENT 4.22-B 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.) _X_ 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. _X_ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Transmittal #84-6
Revision: HCFA-AT-84-2 (BERC) OMB No. 0938-0193
01-84

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.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L. 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services 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. _____Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Transmittal #80-11

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)	
	4.25 Program for Licensing Administrators of Nursing Homes
42 CFR 431.702 AT-78-90	The State has a program that, except with respect to Christian Science sanitoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
1927(g) 4.26 42 CFR 456.700		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

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
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: X Prospective DUR X Retrospective DUR.
1927(g)(2)(A) 42 CFR 456.705(b)	E. l.	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. l.	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.

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
927(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: -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. l.	The DUR program has established a State DUR Board either: X Directly, or _ 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: - 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: - 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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: __OREGON_____

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

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	_X_	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)	_X_	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

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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 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation 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.

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.

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).

Transmittal #88-1
Revision: HCFA-PM-87-14 (BERC) OMB No 0938-0193
OCTOBER 1987

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
	4.30	Exclusion of Providers and Suspension of Practitioners and Other Individuals
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772		(a) All requirements of 42 CFR Part 1002, Subpart B are met.
		___ The agency, under the authority of State law imposes broader sanctions.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)	
	(b) The Medicaid agency meets the requirements of--
1902(p) of the Act P.L. 100-93 (secs. 7)	(1) Section 1902(p) of the Act by excluding from participation--
	(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).
42 CFR 438.808	(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--
	(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
	(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.
1932(d)(1) 42 CFR 438.610	(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).

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 P.L. 100-93 (sec. 8(f))	(2) 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 P.L. 100-93 (sec. 5(a)(4))	(2) 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 State licensing authorities in accordance with section 1921 of the Act.

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OCTOBER 1987

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

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.

Transmittal #88-26
Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)		
	4.34	Systematic Alien Verification for Entitlements
1137 of the Act P.L. 99-603 (sec. 121)		The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements(SAVE), effective October 1, 1988.

___ 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).

___ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

___ Total waiver

___ Alternative system

___ Partial implementation

Transmittal #90-16
Revision: HCFA- PM-90-2 (BPD) OMB No. : 0938-0193
JANUARY 1990

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 Participation

1919(h)(1) and (2) of the Act P.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) of the Act

X (c) The agency establishes alternative State remedies to the specified 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 Act

X (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.

Transmittal #95-15

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

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 Facilities
42 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 §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 Remedies
42 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.

Transmittal No. #95-15

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)			
	c)	Application of Remedies	
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)	Available Remedies	
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).	
	X	(1)	Termination
	X	(2)	Temporary Management
	X	(3)	Denial of Payment for New Admissions
	X	(4)	Civil Money Penalties
	X	(5)	Transfer of Residents; Transfer of Residents with Closure of Facility
	X	(6)	State Monitoring
	Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.		

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)				
42 CFR §488.406(b) §1919(h)(2)(B)(ii) of the Act.	(ii)	X		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).
		X	(1)	Temporary Management
		X	(2)	Denial of Payment for New Admissions
		X	(3)	Civil Money Penalties
		X	(4)	Transfer of Residents; Transfer of Residents with Closure of Facility
		X	(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)	X		State Incentive Programs
		__	(1)	Public Recognition
		X	(2)	Incentive Payments

Transmittal #91-10

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

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.

Transmittal #91-25
Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

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.

Transmittal #92-8

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)			
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)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	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.
	X	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	X	(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.
		(d)	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.
	X	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	X	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

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), 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)).	(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.
	(h)	The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i)	Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j)	Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k)	For program reviews other than the initial review, the State visits the entity providing the program.
	(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).

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), 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.

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), 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.

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.
	X	(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)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	X	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	X	(ee)	ATTACHMENT 4.38 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).
	X	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation(s)

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

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)).

(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.

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

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

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.

Transmittal #92-16
Revision: HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

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 section1919(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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Revision: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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. Attachment 4.40-C 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 that 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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APRIL 1992 OMB No:

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. Attachment 4.40-D describes the State's programs.
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. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(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 finding 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.

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:
	X the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§l919(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 Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

Citation(s)

4.42 Employee Education About False Claims Recoveries

1902(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 1 902(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 1 902(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

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 1 902 (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.

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 1 902(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.

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.

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.

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 <u>Provider Screening and Enrollment</u>** 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 seg. ☒ 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.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSE ☒ 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: __OREGON_____

SECTION 4 –GENERAL PROGRAM ADMINISTRATION

Citation(s)	
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT ☒ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.
42 CFR 455.422	APPEAL RIGHTS ☒ 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.
42 CFR 455.432	SITE VISITS ☒ Assures the pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.
42 CFR 455.434	CRIMINAL BACKGROUND CHECKS ☒ 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.
42 CFR 455.436	FEDERAL DATABASE CHECKS ☒ 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.
42 CFR 455.440	NATIONAL PROVIDER IDENTIFIER ☒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.

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.

Transmittal #80-11

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.

Transmittal #80-11

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]

Transmittal #80-11

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)	
	5.3 Training Programs; Subprofessional and Volunteer Program
42 CFR Part 432, Subpart B AT-78-90	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.

Transmittal #80-11

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)	
	6.1 Fiscal Policies and Accountability
42 CFR 433.32 AT-79-29	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.

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

SECTION 6 FINANCIAL ADMINISTRATION

Citation(s)	
	6.2 Cost Allocation
42 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.

Transmittal #80-11

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)	
	6.3 State Financial Participation
42 CFR 433.33 AT-79-29 AT-80-34	(a) State funds are used in both assistance and administration.
	X 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.

Transmittal #91-25
Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

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.

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,

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

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.

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)

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

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

a. The Oregon Health Authority is the single State agency responsible for:

☒ administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is
ORS 413.032
(statutory citation)

☐ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency's legal authority to make rules and regulations that are binding on political subdivisions administrating the plan is

(statutory citation)

b. A waiver (waivers) of the single State agency requirement

☐ has (have) been granted, as set forth in ATTACHMENT 1.1B.

☒ has (have) not been granted.

12/13/10
Date

Signature in file

Attorney General
Title

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

State/Territory: OREGON

OREGON HEALTH AUTHORITY FUNCTION OVERVIEW

Creation of the Oregon Health Authority

The Seventy –Fifth Oregon Legislative Assembly passed House Bill 2009, signed into law by the Governor in June of 2009, creating the Oregon Health Authority. The Oregon Health Authority is designated as the state Medicaid agency for the administration of funds from Title XIX of the Social Security Act. Legal authority for the Oregon Health Authority to administer Medicaid is found in Oregon Revised Statute chapter 413.

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. OHA duties generally include but are not limited to: Developing the policies for and the provision of publicly funded medical care and medical assistance in this state; Ensuring the promotion and protection of public health and the licensing of health care facilities; Developing the policies for and the provision of mental health treatment and treatment for substance use disorders.

The Oregon Health Authority has Interagency Agreements in place with the Department of Human Services for the determination of Medicaid eligibility and other administrative or operational functions related to the State Medicaid Program as necessary and appropriate.

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

State/Territory: OREGON

See hard copy state plan for chart

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

State/Territory: OREGON

OREGON HEALTH AUTHORITY FUNCTION OVERVIEW

Medical Assistance Unit Operations:

This division has primary responsibility of day-to-day operation of the Medicaid program and coordination with other entities. Specific responsibilities within the Division of Medical Assistance Programs include overseeing Program Operations which includes but is not limited to:

- Program and Policy development;
- Coordination with the Department of Human Services;
- Operating a grievance and appeals function;
- Quality assurance monitoring;
- Claims adjudication;
- Provider and client relations;
- Implementing and revising the state plan;
- Overseeing research and evaluation activities;
- Overseeing managed care activities and monitoring;
- Information services;
- Medical & clinical review.

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

State/Territory: OREGON

See hard copy state plan for chart

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

State/Territory: OREGON

Federal Financial Participation Staff Time Allocation

The Oregon Health Authority and the Department of Human Services use an electronic system to determine the Federal Financial Participation (FFP) allocations for staff. All staff enter data into the reporting system on a monthly basis and their time is allocated to categories such as:

- Approved Advance Planning Documents (APD);
- Drug Utilization Review(DUR);
- Family Planning;
- MMIS Operations;
- HIT planning costs;
- TPR recovery procedures;
- Regular Medicaid Administration; and
- Skilled Medical Professional.

Staff are instructed that only skilled medical professionals may claim time in that category. Staff must complete their time reporting for each month by the 10th day of the following month.

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

State/Territory: OREGON

Eligibility Determinations

Pursuant to Oregon State Law, and as permitted by Medicaid law, the OHA and the Department of Human Services (DHS) have established an agreement regarding the provision of eligibility determination for the Medicaid program. OHA, will establish and implement eligibility policy and procedures across both OHA and DHS Medicaid/CHIP programs consistent with federal statutes and regulations, Both OHA and DHS may have have eligibility determination responsibilities. The agreement defines the roles and responsibilities of the OHA, The Single State Agency, as the administrator of the Medicaid State Plan and the DHS, Title IV-A Agency, as an eligibility determination agency for the Medicaid program.

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

Replaced by ACA TN No. 13-0012 in section 8

~~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:~~

~~X Families with an unemployed parent for 12 months.~~

~~X Pregnant women with no other eligible children.~~

~~X 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.~~

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.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
	2.	Deemed Recipients of AFDC
	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.

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.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
407(b), 1902 ~~(a)(10)(A)(i) and 1905(m)(1) of the Act~~	3.	~~Qualified Family Members~~ ~~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.

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

Replaced by ACA TN No. 13-0012 in section 8

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:~~

~~a. Families denied AFDC solely because of income and resources deemed to be available from --~~

~~(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.~~

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

Replaced by ACA TN No. 13-0012 in section 8

~~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.~~

~~X 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).~~

~~_ 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).~~

~~_ 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.~~

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

Replaced by ACA TN No. 13-0012 in section 8

~~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 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 resource 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~~.

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

Replaced by ACA TN No. 13-0012 in section 8

~~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 Supplement 1 to ATTACHMENT 2.6-A.~~
		~~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.~~
~~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 Supplement 1 to ATTACHMENT 2.6A.~~

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.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10) ~~(A)(i)(V) and 1905(m) of the 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 407 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.

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. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	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
		X 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.
		X Aged X Blind X Disabled

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. 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 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.)
	1619(b)(1) 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

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. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	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 section1905(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

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

(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

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.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1619(b)(3) of the Act	___	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.

*Agency that determined eligibility for coverage

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

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.	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.

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

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

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. 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.

X 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).

X 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).

__ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determined eligibility for coverage

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. 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(I) 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

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

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

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.

X 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.

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified 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 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. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
	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 -- 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.)

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

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(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.

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
		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~~ _ ~~Pregnant women~~
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

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.	Optional Groups Other Than the Medically Needy(Continued)
42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 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 101- 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).

X The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is ___ months (not to exceed six).

The State measures the minimum enrollment period from:

P&I

_ The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

_ 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.

_ 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

P&I 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

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
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.

X 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.

X 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

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.		Optional Groups Other Than the Medically Needy(Continued)
42 CFR 435.217	X	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.
	X	5.	PACE Enrollees.

*Agency that determined eligibility for coverage

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.	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

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

Replaced by ACA TN No. 13-0012 in section 8

~~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.~~

___ ~~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 ago of--~~
___ ~~21~~
___ ~~20~~
___ ~~19~~
___ ~~18~~
___ ~~Caretaker relatives~~
___ ~~Pregnant woman~~

~~435.22~~ ~~7.~~ ___ ~~a. All individuals who are not described in section1902(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.~~

~~42 CFR 435.2~~
~~1902(a)(10)(A)(ii) and 1905(a)(i) of the Act~~

___ ~~20~~
___ ~~19~~
___ ~~18~~

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

Replaced by ACA TN No. 13-0012 in section 8

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

~~42 CFR 435.222~~ ~~X~~ ~~b. Reasonable classifications of individuals described in (a) above, as follows:~~

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

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

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

~~(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 ___)~~

~~X (3) Individuals in NFs (who are under the age of 21). NF services are provided under this plan.~~

~~X (4) In addition to the group under (b)(3), individuals in ICFS/MR (who are under the age of 21)~~

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

Replaced by ACA TN No. 13-0012 in section 8

~~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.~~

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
		Replaced by ACA TN No. 13-0012 in section 8
		~~B. Optional Groups Other Than the Medically Needy (Continued)~~
~~l9O2(a)(10)(A)(ii)(VIII) of the Act~~	~~X~~	~~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 -~~
		~~a. Was eligible for Medicaid under the State's approved 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
		X 18

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
		Replaced by ACA TN No. 13-0012 in section 8
	~~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)(A)(ii) and 1905(a) of the Act~~		~~Individuals under the age of--~~
		~~21~~
		~~20~~
		~~19~~
		~~15~~
		~~Caretaker relatives~~
		~~Pregnant women~~

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. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 ___ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

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

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. 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:

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. 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.

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.	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.

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. Optional Groups Other Than the Medically Needy (Continued)

X (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

X (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

X (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.

X (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:

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. Optional Groups Other Than the Medically Needy (Continued)

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

__ Yes

X No

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

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. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231
1902(a)(10)
(A)(ii)(V)
of the Act

X 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. 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

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

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.

~~1902(a)(10)(A)(ii)(IX) and 1902(1) of the Act~~ — ~~X~~ ~~14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6--A:~~

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.

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
		Replaced by ACA TN No. 13-0012 in section 8 for partial items removed
	~~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 to100 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.

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.	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.

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
		Replaced by ACA TN No. 13-0012 in section 8
		~~B. Optional Groups Other Than the Medically Needy (Continued)~~
~~1902(a)(47) and 1920 of the Act~~	~~17.~~	~~Pregnant women who are determined by a "qualified 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.~~

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.	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.

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.		Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XIII) of the Act	[X]	20.	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.
1902(a)(10)(A)(ii)(XVIII) of the Act	[X]	21.	Women who: 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.

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

Replaced by ACA TN No. 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.~~

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. Optional Coverage Other Than the Medically Needy (Continued)

1902(e)(12) of the Act X 23. Continuous Eligibility for Children.
A child under age 19 (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 12 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.

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

Replaced by ACA TN No. 13-0012 in section 8

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

~~Sections 477, 1902(a)(10)(A)(ii)(XVII), and 1905(w) of the Act~~

~~24. Independent Foster Care Adolescents.~~

~~An individual who is younger than age 21, who on the individual's 18th 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: _X_ 21~~
~~__ 20~~
~~__ 19~~

~~2) Are: _X_ All such individuals.~~
~~__ 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.~~
~~__ Other reasonable classifications:~~

~~b. Financial requirements~~

~~1) Income test: _X_ There is no income test.~~
~~__ The income test is:~~

~~2) Resource test: _X_ There is no resource test.~~
~~__ The resource test is:~~

~~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.~~

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.	Optional Coverage of the Medically Needy
42 CFR 435.301		This plan includes the medically needy.
		X No.
		_____ 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.

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. Optional Coverage of the Medically Needy (Continued)

42 CFR 435.308

4. (left blank in tentionally)

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).

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. Optional Coverage for the Medically Needy (Continued)

__ (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 ATTACHMENT 2.2-A.

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.	Optional Coverage for the Medically Needy (Continued)
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 f or 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.

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. 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	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.

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

Replaced by ACA TN No. 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.~~

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

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	See ACA TN No. 13-0012 in section 8 for partial items removed
	A. General Conditions of Eligibility
	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. 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	3. Is residing in the United States (U.S.),and--
	~~a. Is a citizen or national of the United States;~~
	~~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;~~
	~~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~~;

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

~~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.~~
~~_X_ 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

Replaced by ACA TN No. 13-0017 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.~~

_X_ ~~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

Replaced by ACA TN No. 13-0017 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.~~

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. 13-0012 in section 8

~~A. General Conditions of Eligibility (continued)~~

~~42 CFR 435.403 1902(b) of the Act~~	~~4.~~	~~Is a resident of the State, regardless of whether or not the individual 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.~~

HCFA ID: 7985E

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	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 ago 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.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
		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)).

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. 13-0012 in section 8
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) and (B) of the Act~~	~~9. 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 ouch requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)~~

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).

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 lndividual'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 made 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	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: Personal Needs Allowance PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 60.00 Couples $ 120.00 *Periodically adjusted based upon SSA COLA increases. For the following individuals with greater need: Supplement 12 to Attachment 2.6-A 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. b. AFDC related: Children $ 30.00 Adults $ 30.00 For the following individuals with greater need: Supplement 12 to Attachment 2.6-A 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. c. Individuals under age 21 covered in this plan as specified in Item B.7. of ATTACHMENT 2.2-A. N/A

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 Attachment 2.6-A 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	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: 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. X The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level. ___ 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.) ___ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). 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.

Supersedes TN No.

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: X the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or __ 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: X 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. __ 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 ATTACHMENT 2.6-A.)

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	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: 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: • AFDC level; or • Medically need level: (Check one) ___ AFDC levels in Supplement 1 XX Medically needy level in Supplement 1 ___ other: $ 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. (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 Supplement 3 to ATTACHMENT 2.6-A.
435.725 433.733 433.832	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: 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: ___ No XX Yes (the applicable amount is shown on page 5a.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
	____	Amount of maintenance of home is: $_____.
	____	Amount of maintenance of home is the actual maintenance costs not to exceed $_____.
	____	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.
	____	Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.
	X	Amount for maintenance of home is the actual maintenance costs, no upper limit.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
See ACA TN No. 13-0012 in section 8 for partial items removed		
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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
X	Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
__	Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
__	Supplement 4 to ATTACHMENT 2.6-A 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.
__	Supplement 5 to ATTACHMENT 2.6-A 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.
__	Supplement 8a to ATTACHMENT 2.6-A 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.
X	Supplement 8b to ATTACHMENT 2.6-A 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.
__	Supplement 14 to ATTACHMENT 2. 6 -A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) 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
See ACA TN No. 13-0012 in section 8 for partial items removed	
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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B) (m)(4) and 1902 (r)(2) of the Act	b.	Aged individuals. 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: ___ The methods of the SSI program only. _X_ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	___ 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 Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	X 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.
	X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	X SSI methods only.
	__ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	__ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: __ The methods of the SSI program only. X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ 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 Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. X 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 8a to ATTACHMENT 2.6-A. X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- X SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

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

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.
		X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
		X 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

X SSI methods only.

_ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to Attachment 2.6-A

_ 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 Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

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.

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. 13-0012 in section 8 for partial items removed

~~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.~~

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
		See ACA TN No. 13-0012 in section 8 for partial items removed
		~~(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 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.	Qualified Medicare beneficiaries. 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.
		X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
		X For institutional couples, the methods specified under section 1611(e)(5) 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
	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. 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 date of publication.
1905(s) of the Act g. (1)	Qualified disabled and working individuals. 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.
1905(p) of the Act (2)	Specified low-income Medicare beneficiaries. 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
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).

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) (ii)(XIII) of the Act	(i)	Working Disabled Who Buy Into Medicaid In determining countable income and resources for Working Disabled individuals who buy into Medicaid, the following methodologies are applied: ___ The methodologies of the SSI program. ___ 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. X 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. X 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. .

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

ESTABLISHMENT AND APPLICATION OF A PREMIUM
OR OTHER COST SHARING CHARGES

[ ] Section 1902(f) State [X] 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.

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	2.	Medicaid Qualifying Trusts 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. ___ 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. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3.	Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR.435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only a. Medically Needy (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. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. ____ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	a. Medically Needy (Continued)
1903(f)(2) of the Act	_ (3) If countable income exceeds the MNIL standard, the agency deducts spend down payments made to the State by the individual.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	b. Categorically Needy - Section 1902(f) States
42 CFR 435.732	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: (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 Attachment 2.6-A. Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States -Continued
1903(f)(2) of Act	_ (6) Spend down payments made to the State by the the individual.
	NOTE: FFP will be reduced to the extent a State is paid a spend down payment by the individual.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(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 Supplement 8b to ATTACHMENT 2.6-A.

(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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	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.
	X 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.

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
		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. X 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
See ACA TN No. 13-0012 in section 8 for partial items removed		
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and (C), and 1902(r)(2) of the Act	d.	Disabled individuals, including individuals covered under section 1902(a)(10(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: __ The methods of the SSI program. X 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 that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. 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.
~~1902(l)(3) and 1902(r)(2) of the Act~~	~~e.~~	~~Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.~~ ~~The agency uses the following methods in the treatment of resources.~~ ~~__ The methods of the SSI program only.~~ ~~__ The methods of the SSI program and/or any more liberal methods described in Supplement 5a of Supplement 8b to ATTACHMENT 2.6-A.~~

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. 13-0012 in section 8 for partial items removed		
		~~_ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.~~
		~~X Not applicable. The agency does not consider resources in determining eligibility.~~
		~~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.~~
~~1902(l)(3) and 1902(r)(2) of the Act~~	~~f.~~	~~Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.~~
		~~The agency uses the following methods for the treatment of resources:~~
		~~_ The methods of the State's approved AFDC plan.~~
~~1902(1)(3)(C) of the Act~~		~~_ 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 Supplement 5a of ATTACHMENT 2.6-A.~~
~~1902(r)(2) of the Act~~		~~_ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.~~
		~~X Not applicable. The agency does not consider resources in determining eligibility.~~

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. 13-0012 in section 8	
~~1902(l)(3) and 1902(r)(2) of the Act~~	~~g. 1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act.~~
	~~The agency uses the following methods for the treatment of resources:~~
	~~_ The methods of the State's approved AFDC plan.~~
~~1902(l)(3)(C) of the Act~~	~~_ 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 Supplement 5a of ATTACHMENT 2.6-A.~~
~~1902(r)(2) of the Act~~	~~_ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.~~
	~~X Not applicable. The agency does not consider resources in determining eligibility.~~
	~~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~~

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. 13-0012 in section 8	
~~1902(l)(3) and 1902(r)(2) of the Act~~	g. 2. ~~Poverty level children under section1902(a)(10)(A)(i)(VII)~~
	~~The agency uses the following methods for the treatment of resources:~~
	~~_ The methods of the State's approved AFDC plan.~~
~~1902(l)(3)(C) the Act~~	~~_ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 8a of ATTACHMENT 2.6-A.~~
~~1902(r)(2) of the Act~~	~~_ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A.~~
	~~X 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.~~

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)			Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5.	h.	For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: __ The methods of the SSI program only. X The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
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 Supplement 5 to Attachment 2.6-A.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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.

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. 13-0012 in section 8	
~~1902(1)(3)(A) (B) and (C) of of the Act~~	~~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.~~
	~~__ Yes. Supplement 2 to ATTACHMENT 2.6-A 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.~~
	~~X No. The agency does not apply a resource standard to these individuals.~~
~~1902(l)(3)(A) and (C) of the Act~~	~~d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.~~
	~~__ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.~~
	~~X No. The agency does not apply a resource standard to these individuals.~~
~~1902(1)(3)(A) and (D) of the Act~~	~~e. For children covered under the provisions of section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard.~~
	~~__ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.~~
	~~__ No. The agency does not apply a resource standard to these individuals.~~

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	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: __ 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). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	7. Resource Standard - Medically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act	b. A single standard is employed in determining resource resource eligibility for all groups.
	___ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--
	___ Aged ___ Blind ___ Disabled
	Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals
	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.

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)(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 Supplement 8 to Attachment 2.6-A.

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

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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility 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. X Aged, blind, disabled. X AFDC-related. X MAGI. Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements. ___ Aged, blind, disabled. ___ AFDC-related. ___ 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: ___ Aged, blind, disabled. ___ AFDC-related. ___ 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. X Aged, blind, disabled. X AFDC-related. X MAGI.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)			Condition or Requirement
See ACA TN No. 13-0012 in section 8 for partial items removed			
1920(b)(1) of the Act	_		~~(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 ATTACHMENT 2.6-A 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.~~
1902(e)(8) and 1905(a) of the Act	X	b.	For qualified Medicare beneficiaries defined in section 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-- X 12 months _ 6 months _ __ months (no less than 6 months and no more than 12 months)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(a)(18) and 1902(f) 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 Supplement 9 to Attachment 2.6-A.
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 Supplement 9(a) to ATTACHMENT 2.6-A, 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. __ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts; X The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller 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 Supplement 10 to ATTACHMENT 2.6-A.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
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; X the minimum standard permitted by law; or $____ a standard that is an amount between the minimum and the maximum.

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. 13-0012 in section 8

~~INCOME ELIGIBILITY LEVELS~~

~~A. MANDATORY CATEGORICALLY NEEDY~~

~~1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:~~

~~Family Size~~	~~Need Standard~~	~~Payment Standard~~	~~Maximum Payment Amounts~~
~~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)~~

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. 13-0012 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~~.

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. 13-0012 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).~~

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. 13-0012 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.~~

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.

Family Size	Income Level
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.

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)

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:

Family Size	Income Level
1	$776
2	1,041

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)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, ~~1989~~ 1987 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:

Family Size	Income Levels
1	$
2	$

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) | Condition or Requirement

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 ___1___ months	Amount by which Column (2) exceeds limits specified in1/ 42 CFR 435.1007	Net income level for persons living in rural areas for _____months	Amount by which Column (4) exceeds limits specified in1/ 42 CFR 435.1007
___ Urban only ___ 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) | Condition or Requirement

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) Family Size	(2) Net income level protected for maintenance for 1 months	(3) Amount by which Column (2) exceeds limits specified in1/ 42 CFR 435.1007	(4) Net income level for persons living in rural areas for ____ months	(5) Amount by which Column (4) exceeds limits specified in1/ 42 CFR 435.1007
__ Urban only X 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.

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. 13-0012 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.~~

~~X Less restrictive than SSI resource levels and is as follows:~~

~~Family Size~~	~~Resource Level~~
~~1~~	~~N/A~~
~~2~~	~~N/A~~

~~b. Optional Groups~~

~~___ Same as SSI resources levels.~~

~~X Less restrictive than SSI resource levels and is as follows:~~

~~Family Size~~	~~Resource Level~~
~~1~~	~~N/A~~
~~2~~	~~N/A~~

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. 13-0012 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:~~

~~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~~

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. 13-0012 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:~~

~~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~~

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. 13-0012 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~~

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. 13-0012 in section 8

~~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~~
~~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~~

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. 13-0012 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.~~

~~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~~

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

4. Aged and Disabled Individuals

___ Same as SSI resource levels.

___ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

___ Same as medically needy resource levels (applicable only if State has a medically needy program)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

___ Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

For each additional person

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

N/A

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) | Condition or Requirement

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level Gross		Income Level Net		Income Disregards Employed
	Federal	State	1 person	Couple	1 person	Couple	
(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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

INCOME LEVELS FOR 1902(F) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

N/A

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

N/A

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

Replaced by ACA TN No. 13-0012 in section 8

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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.

~~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
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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
State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

MORE LIBERAL METHODS OF TREATING UNEARNED INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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 is 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

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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:

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:
   (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:
   (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; and
5. 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

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State [X] 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
	STATE LONG-TERM CARE INSURANCE PARTNERSHIP
1902(r)(2) 1917(b)(1)(C)	The following more liberal methodology applies to individuals who are 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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

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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	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
	No individual is ineligible by reason of item A.2 if-- 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; 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; 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 iv. The agency determines that denial of eligibility would work an undue hardship. 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.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

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:

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	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:

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) P&I — 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. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

___ The State uses the first day of the month in which the assets were transferred

_X__ The State uses the first day of the month after the month in which the assets were transferred

or

- 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;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

_X__ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ 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.

5. Penalty Period - Non-institutionalized Individuals--
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;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

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

6. Penalty period for amounts of transfer less than cost of nursing facility care--

_X__ 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.

_X__ 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.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(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.

8. Treatment of a transfer of income—

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.

_X__ For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

_X__ 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.

9. Imposition of a penalty would work an undue hardship--

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:

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

Application of a transfer of assets penalty would deprive the individual:

(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. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(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.

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.

11. Bed Hold Waivers For Hardship Applicants

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:

____ 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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

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 $_____.

State/Territory: OREGON

Citation	Condition or Requirement

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oregon

Replaced by ACA TN No. 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).~~

Replaced by ACA TN No. 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.~~

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 loner 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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Replaced by ACA TN No. 13-0012 in section 8

ELIGIBILITY CONDITIONS AND REQUIREMENTS

~~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~~.

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:

__X__ $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.

X 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.

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** 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".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		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** 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".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		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.

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).

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ____OREGON

FINANCIAL ELIG1BILITY CONDITIONS AND REQUIREMENTS

I. GENERAL-APPLICABLE TO THE CATEGORICKLLY NEEDY AND MEDICALLY NEEDY

A. Financial responsibility is imposed on the following relatives with respect to care and services provided under the plan:

1. Spouse for spouse

_X_ Yes.

___ Yes, with the following exceptions:

___ No responsibility is imposed

2. Parents for children under age 21

___ Yes.

_X_ 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

_X_ Yes.

___ Yes, with the following exceptions:

___ No responsibility is imposed

4. Parents for children of any age who are disabled

_X_ Yes.

___ Yes, with the following exceptions:

____ No responsibility is imposed

B. _X_ 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.

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.

LIMITATIONS ON SERVICES

l . 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.

State/Territory: Oregon

AMOUNT, DURATION, AND SCOPE OF MEDICALAND 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.

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/main.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 noncovered 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.

6. a. Podiatrist Services
Selected procedures require prior authorization of payment. Routine foot care is excluded from coverage.

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.)

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 polarthropathies, 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.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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

6. d. Other Practitioner Services

Licensed practitioners;

In accordance with 42 CFR 440.60, the following licensed practitioners are covered for services within their scope of practice as defined in Oregon Revised Statutes, 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:

1. Naturopathic physicians;
2. Licensed non-nurse Direct Entry Midwives;
3. Acupuncturists;
4. Denturists;
5. Dental hygienists with an Expanded Practice Dental Hygienist Permit (EPDHP);
6. Certified Registered Nurse Anesthetist (CRNA);
7. Certified Nurse Practitioners, includes all specialty designations;
8. Physician Assistants;
9. Ph.D Psychologists, PsyD Psychologists, Licensed Clinical Social Workers and Licensed Professional Counselors;
10. Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA).

Non-licensed practitioners:

1. Behavioral Analyst Interventionists

Must be supervised by a licensed Board Certified Behavior Analyst, a licensed Board Certified Assistant Behavior Analyst or a Licensed Health Care Professional.

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

6. d. Other Practitioner Services (Cont)

Non-licensed practitioners (Cont):

2. Non-traditional health workers (referred to a traditional health workers 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*, Certified 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 Wellness Specialist services are provided under the supervision of LHCP;
c) Personal Health Navigators services are provided under the supervision of LHCP;
d) Doula services are provided under the supervision of a Physician (M.D. and D.O.) or a Certified Nurse Practitioner.

The state assures that only the Licensed Health Care Professional will bill for 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

LIMITATIONS ON SERVICES (Cont.)

7. a. Home Health Care Services

Coverage and provider qualifications are in accordance with 42 CFR 440.70. Intermittent or part-time nursing services are provided to eligible clients in their homes according to a written plan of treatment. Home health services must be prescribed by a physician and the signed order must be on file at the Home Health Agency. The plan of care must be reviewed and signed by the physician every 60 days to continue services. 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.

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.)

7. c. Medical Supplies in the Patient's Home

Medical supplies, equipment and appliances suitable for use in the home are provided when medically necessary and prescribed by a treating 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 service. The medical equiptment 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.

DMEPOS items are not covered include, but is not limited to; when the item is not primarily medical in nature; for personal comfort or convenience of client or caregiver; a self-help device; not therapeutic or diagnostic in nature; inappropriate for client use in the home (e.g., institutional equipment like an oscillating bed); for a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines.

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.)

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.

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.)

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;

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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

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.

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

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.

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.)

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;

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.)

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 biscuspid 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.

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.)

11a. Physical Therapy

Coverage and provider qualifications are 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 PA, but are limited to: two initial evaluations in any 12-month period; and up to four re-evaluation services in any 12-month period. All other therapy modalities require a PA. Therapy treatments must not exceed one hour per day for physical therapy and up to two modalities may be authorized per day of treatment. Additional modalities can be authorized due to medical necessity. Services that are not covered: back school/back education classes, hippo-therapy, maintenance therapy, work hardening or services that are not medically appropriate.

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 prior authorization of services. Initial evaluations and re-evaluations do not require PA, but are limited to two initial evaluations in any 12-month period; and up to four re-evaluation services in any 12-month period. All other therapy modalities require a PA Therapy treatments must not exceed one hour per day and up to two modalities may be authorized per day of treatment. Additional modalities can be authorized due to medical necessity. Services that are not covered: back school/back education classes, hippo-therapy, maintenance therapy, work hardening or services that are not medically appropriate.

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.)

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 plan of treatment. Services authorizations are based upon medical necessity review. Services that require a prior authorization are: Speech pathology therapy treatment; Speech-generating/augmentative communication system or device; Repair/modification of a speech-generating/augmentative communication system or device ;Hearing aids; Repair of hearing aids, including ear mold replacement; Hearing aid dispensing and fitting fees; Assistive listening devices; Cochlear implant batteries. Services that are not covered: FM systems -- vibro-tactile aids; Earplugs; Tinnitis masker(s) or services that are not medically appropriate.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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.)

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.

The OHA will maintain a list of drugs to be referred to as the Practitioner Managed Preferred Drug List (PDL). The PDL is a listing of prescription drugs that the OHA has determined represents the most effective drug(s) at the best possible price for the selected drug classes. The PDL will be developed by the combined Drug Use Review Board (DUR) and the Pharmacy & Therapeutics Committee using any information it deems appropriate including information gathered from non-evidence based processes. The PDL will include other drugs in the class that are Medicaid reimbursable and which the FDA has determined to be safe and effective when the DUR/P&T Committee differentiates substantial cost differences between drugs in the same class.

A practitioner may prescribe any Medicaid reimbursable, FDA approved drug that is not listed on the PDL, however if the drug is not on the PDL the prescriber must obtain a Prior Authorization (PA). Mental Health drugs in therapeutic class 7 and 11, clients with a prescription written prior to 1/1/2010 and a drug in a class that has not been evaluated for the PDL are exempt from the PA requirement. In order to obtain a PA the practitioner may phone or fax a 24/7, toll-free number to reach the health plan's pharmacy benefits manager. The prescriber will speak with a pharmacy technician or with a registered pharmacist who will ask about the medical diagnosis being treated and whether he or she has tried a generic or another drug on the preferred drug list. Prior approval is granted when a medical diagnosis is covered by the Oregon Health Plan HSC list of health services and medical history or patient risk indicates the drug is needed. Approvals or denial responses are issued within 24 hours of the prior authorization request. If prior approval is denied, both the physician and patient receive a letter explaining why and outlining appeal procedures. Pharmacies are authorized to dispense a 72 hour supply of a product that has prior authorization criteria in the event of an emergency. The program complies with requirements set forth in Section 1927 (d)(5) of the Social Security Act pertaining to prior authorization programs.

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.)

12.a. Prescribed Drugs (Cont.)

Regardless of the PDL, prescriptions shall be dispensed in the generic form unless practitioner requests otherwise subject to the regulations outlined in 42 CFR 447.512.

The state utilizes The Oregon State University College of Pharmacy for literature research and the state's DUR and Pharmacy & Therapeutics Committee as the Prior Authorization committee. Criteria used to place drugs on Prior Authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug.

The combined DUR and Pharmacy and Therapeutics Committee members are appointed by the OHA Director, or his designee's and consists of five (5) practicing physicians, four (4) practicing pharmacists, and two (2) members of the public who are non-pharmacists or physicians.

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 (Cont.)

12.a. Prescribed Drugs

Rebate Agreement:

The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. The state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates;
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D);
- The state is in compliance with reporting requirements for utilization and restrictions to coverage;
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement;
- Funds received from supplemental rebates will be reported to CMS;
- The state will remit the federal portion of any supplemental rebates collected at the same percentage basis as applied under the national rebate agreement.

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.

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 (Cont.)

12.a. Prescribed Drugs

Supplemental Rebate Agreement (Cont):

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.

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 if the products are on the Medicaid MCO formularies (Version 1 of Attachment A, Transmittal 10-13).

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.)

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 equiptment 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.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

LIMITATIONS ON SERVICES (Cont.)

13.c. Preventive Services

Immunization is provided for individuals against diphtheria, pertussis, tetanus, polio, measles (rubeola), mumps, rubella (German measles) where such immunization is not available without cost through a local Health Department.

Immunizations are provided for individuals in conjunction with exposure to or affliction with specific disease entities. Such entities include rabies, influenza, pneumococcal pneumonia, hepatitis, botulism, snake bite, etc., as well as some of those mentioned above where such immunization is not available without cost through the local Health Department, or other source.

Payment will be made for vaccines prescribed by a physician as a legend drug (such practice is followed to protect nursing home residents against influenza or pneumonia where there has been exposure or likelihood of exposure).

13d. Rehabilitative Services in Psychiatric Treatment Centers

Rehabilitation services are the core medical or remedial services to be provided on a state-wide basis to eligible Medicaid recipients through facilities comparable to day treatment centers. All participating facilities must meet Children's Services Division and Mental Health Division standards for day treatment programs and therefore have the capacity and professional staffing to provide complete services in all designated core areas. These core areas are defined as follows:

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

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 waivered 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.

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.

(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.

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

13.d. Rehabilitative: Mental Health Services

Mental health rehabilitative services include coordinated assessment, therapy, consultation, medication management, skills training 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
- Mental Health Services provided in to children, adolescent and adults in Residential settings (includes intensive rehabilitative treatment);
- Peer Support;
- Rehabilitation Mental Health Case Management'
- Skills training.

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

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.

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

13.d. Rehabilitative: Mental Health Services (Cont)

Crisis and Stabilization services:
Evaluation and treatment of mental health crisis to individuals experiencing a crisis. A mental health 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 mental health professional. Stabilization services may be provided prior to an intake evaluation for mental health services. Providers authorized to provide these services include LMP, QMHP and mental health interns under appropriate supervision.

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.

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

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.

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

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.

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

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 Case Management:
To be eligible, the individual must be in need of case management 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 training:
Provides a range of integrated and varied life skills training (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.

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

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.

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

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

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

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

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

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.

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

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.

The Oregon Health Authority (OHA) provides SUD treatment services through approved managed care organizations; Coordinated Care Organizations (CCOs), Fully Capitated Health Plans (FCHPs), and Physician Care Organization (PCO), Community Mental Health Programs (CMHPs) or through direct contracted providers. The CCOs, FCHPs and PCO may provide services directly, or through subcontract providers in a variety of settings.

OHA requires that CCOs, FCHPs, PCO, CMHPs and providers use the American Society of Addition Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care.

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 are for the "maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level".

SUDs TREATMENT SERVICE COMPONENTS

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.

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

13.d. Rehabilitative: Substance Use Disorder Services:
Screening (Cont): Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

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 an integrated service and support plan (ISSP) with the individual's input in setting their treatment goals. The duration/frequency of the treatment services are determined utilizing ASAM PPC-2R, the ISSP and the individual's needs. 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 ISSP. The duration/frequency of the treatment services are determined utilizing ASAM PPC-2R, the ISSP and the individual's needs. . Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

Group counseling/ Group family and/or couple counseling therapy services provided is 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 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 ISSP.

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

13.d. Rehabilitative: Substance Use Disorder Services:

Group counseling/ Group family and/or couple counseling (Cont) 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, CADC and interns under appropriate supervision as defined in the provider qualification section.

Care coordination is provided to an individual with complex needs in order to ensure timely and appropriate treatment and care. Activities include assessment and ongoing re-assessment, 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. 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, 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 ISSP. Providers authorized to provide these services include LMP, QMHP, CADC.

Medication management and monitoring 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.

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

13.d. Rehabilitative: Substance Use Disorder Services:

Medication management and monitoring (Cont) 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 and interns under appropriate supervision as defined in the provider qualification section.

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 ISSP. Providers authorized to provide these services include Acupuncturist, LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

Detoxification 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 two ASAM treatment levels of detoxification services, clinically managed and medically monitored detoxification.

Clinically managed detoxification is an organized service that provides 24-hour structure, support, supervision, and observation for individuals who are intoxicated or 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.

Medically monitored detoxification is delivered by licensed medical and nursing professionals, who have specialized training in substance use disorders and which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. 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. Providers authorized to provide these services include LMP, QMHP, CADC and interns under appropriate supervision as defined in the provider qualification section.

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

13.d. Rehabilitative: Substance Use Disorder Services:

Peer Support 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. 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.

LIMITATION ON SERVICES

Limitation and duration/frequency of services are dependent upon each individual's medical needs and outlined in their ISSP. Medically necessary rehabilitative services are provided without limitation in amount, duration and scope in accordance with clinical treatment guidelines, indications and usage.

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 Practitioners (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

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

13.d. Rehabilitative: Substance Use Disorder Services (Cont)
Provider qualifications (cont):

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:

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.

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

13.d. Rehabilitative: Substance Use Disorder 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. 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

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
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.

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

13.d. Rehabilitative: Substance Use Disorder Services (Cont)
Provider qualifications (cont):

4. Must also hold a Certification of Alcohol and Drug Counseling.
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 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, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or

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

13.d. Rehabilitative Substance Use Disorder Services (Cont)
Provider qualifications (cont):
E. "Peer-Support" Specialist (Cont)

3. Is a family member of an individual who is a current or former recipient of addictions or mental health services.

Peer Support Specialists require 20 hours of continuing education every three years.
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. "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.

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

13.d. Rehabilitative: Substance Use Disorder Services:

Provider qualifications (cont):

LMPs, QMHPs, QMHAs, CADC Peer Support Specialists, Acupuncturists 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 substance use disorder 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.
For treatment staff holding certification in addiction counseling, qualification for the certification must include at least: 750 hours of supervised experience in substance use counseling; 150 contact hours of education and training in substance use related subjects; and successful completion of a written objective examination or portfolio review by the certifying body. For treatment staff holding a health or allied health provider license, the license or registration must have been issued by one of the following state bodies and the person must possess documentation of at least 60 (120 for supervisors) contact hours of academic or continuing professional education in substance use disorder treatment; Board of Medical Examiners; Board or Psychologist Examiners; Board of Licensed Clinical Social Workers, Board of Licensed Professional Counselors and Therapists; or Board of Nursing.

All treatment staff must demonstrate competence in treatment of substance use disorders including individual assessment and individual, group, family and other counseling techniques, programs policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes.

IMD ASSURANCE
Residential treatment services for SUDs are provided to Medicaid title XIX eligible individuals in facilities with 16 or fewer beds. Payment is excluded for individuals in “institutions of mental diseases” (IMDs) defined per 42 CFR 435.1010.

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

(Reserved for future use)

LIMITATION ON SERVICES

13.d. School-Based Rehabilitative Services

School-based rehabilitative services are health-related services that:

a) address the physical or mental disabilities of a child;
b) recommended by health care professionals; and
c) are identified in a child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

School-based services are delivered by providers who meet the federal requirements listed below, and who operate within the scope of their practitioner's license and/or certification pursuant to state law as follows:

1. Physical Therapists that meet the federal requirements at 42 CFR 440.110(a), and are licensed by the State Physical Therapist Licensing Board.

Physical Therapy Evaluations and Treatments**:** assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving treatments such as:

- Neuromotor or neurodevelopmental assessment;
- Assessing and treating problems related to musculo-skeletal status;
- Gait, balance, and coordination skills;
- Oral motor assessment;
- Adaptive equipment assessment;
- Gross and fine motor development;
- Observation of orthotic devices; and
- Prosthetic training.

2. Occupational Therapists that meet the federal requirements at 42 CFR 440.110(b), and are licensed by the State Occupational Therapy Licensing Board.

Occupational Therapy Evaluations and Treatments: Assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; and obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services such as:

LIMITATION ON SERVICES (continued)

- Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);
- Gross and fine motor development;
- Feeding or oral motor function;
- Adaptive equipment assessment;
- Prosthetic or orthotic training;
- Neuromotor or neurodevelopmental assessment;
- Gait, balance and coordination skills;

3. Speech Pathologists that meet the federal requirements at 42 CFR 440.110(c), and are licensed by the State Board of Examiners for Speech Pathology and Audiology or hold a Certificate of Clinical Competency from the American Speech and Hearing Association.

Speech Evaluation and Therapy Treatments**:** Assessment of children with speech and/or language disorders; diagnosis and appraisal of specific speech and/or language disorders; referral for medical and other professional attention, necessary for the rehabilitation of speech and/or language disorders; provision of speech or language services for the prevention of communicative disorders; and obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services such as:

- Expressive language;
- Receptive language;
- Auditory processing, discrimination, perception and memory;
- Vocal quality;
- Resonance patterns;
- Phonological;
- Pragmatic language;
- Rhythm or fluency;
- Feeding and swallowing assessment.

4. Audiologists that meet the federal requirements at 42 CFR 440.110(c), and are licensed by the State Board of Examiners for Speech Pathology and Audiology or hold a Certificate of Clinical Competency from the American Speech and Hearing Association.

Audiological Evaluation and Services: Assessment of children with hearing loss; determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services such as:

LIMITATION ON SERVICES (continued)

- Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Central auditory function;
- Testing to determine the child's need for individual amplification;
- Auditory training;
- Training for the use of augmentative communication devices.

5.a. Registered Nurses and Licensed Practical Nurses must have graduated from a state-approved nursing program with a practical nursing certificate, diploma, or an associate, baccalaureate or Masters Degree in nursing; or from an equivalent program in a school of nursing outside of the United States or its jurisdictions and must have passed the State Board Test Pool Examination (SBTPE) before 1988, or the National Council Licensure Examination (NCLEX) after 1988; and be licensed to practice in Oregon by the Oregon State Board of Nursing. A Licensed Practical Nurse (LPN) may participate in the implementation of the plan of care for providing care to clients under the supervision of a licensed Registered Nurse, Nurse Practitioner, or Physician.

5.b. Nurse Practitioners that meet the federal requirements at 42 CFR 440.166, and are licensed by the Oregon State Board of Nursing to practice in Oregon as a Nurse Practitioner.

Nurse Evaluation and Treatment Services: Assessments, treatment services, and supervision of delegated health care services provided to prevent disease, disability, other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. Supervision for services provided to coordinating care and integrating nursing tasks and services that can be performed in the educational setting such as:

- Monitoring patient's seizure activity for breathing patterns, onset/duration of seizure, triggers/auras, level of consciousness, support after seizure, administering medication as ordered;
- Monitoring/providing treatment for high and low blood sugar, checking urine keytones, blood glucose testing, carbohydrate calculations, assisting with insulin administration;
- Ventilator Care suctioning, equipment management;
- Tracheotomy Care changing dressings, emergency trach replacement, suctioning, changing "nose", provide humidification as necessary;
- Catheterization assisting with or performing procedure for catheterization, monitor urinary tract infections, performing skin integrity checks;

LIMITATION ON SERVICES (continued)

- Gastrostomy Tube feeding administering tube feedings per physician order, monitoring skin status around the tube, emergency treatment for button dislodgement;
- Medication pumps, e.g., insulin pump, calculate carbohydrate amounts in food/snacks, provide insulin bolus per physician order, emergency disconnect procedure, monitoring blood sugar;
- Medication management, e.g., monitoring signs and symptoms for medication administration, administering medications, observing for side effects.

6.a. Certified Social Worker Assistant (CSWA) or Licensed Clinical Social Worker (LCSW): must possess a master's degree from an accredited college or university accredited by the Council on Social Work Education and have completed the equivalent of two years of full-time experience in the field of clinical social work in accordance with rules of the Oregon State Board of Clinical Social Workers for a LCSW or whose plan of practice and supervision has been approved by the board, for a CSWA working toward LCSW licensure under the supervision of a LCSW for two years of post masters clinical experience and is licensed by the State Board of Clinical Social Workers to practice in Oregon.

6.b. Psychologists must have one of the following: a doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the State Board of Psychologist Examiners by rule; and have two years of supervised employment under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the board to have equivalent supervisory competence.

6.c. Psychiatrists must be licensed to practice medicine and surgery in the State of Oregon; and possess a valid license from the Oregon Licensing Board for the Healing Arts.

Mental Health Evaluation and Treatment Services Assessments and treatment services, to prevent disease, disability, other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. Coordinating care and integrating out patient mental health services that can be performed in the educational setting such as:

- Mental health assessment;
- Psychological testing (non-educational cognitive and adaptive testing);

LIMITATION ON SERVICES (continued)

- Assessment of motor language, social, adaptive, and/or cognitive functioning by standardized developmental instruments;
- Behavioral health counseling and therapy;
- Psychotherapy (group/individual).

Services for physical therapy, occupational therapy, speech therapy, hearing services, nursing services, and mental health services must be recommended by a physician or other practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist, occupational therapist, speech pathologist, audiologist, Nurse, Nurse Practitioner, Psychiatrist, Psychologist, or Social Worker qualified and licensed to deliver the service.

Medicaid covered services and treatments are provided in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an IEP/IFSP eligible under IDEA in the educational setting. The above-listed therapy services and treatments are examples of services that may be provided to eligible recipients in an educational setting under Oregon's Medicaid program.

13.e. Behavior Rehabilitation Services

Behavior Rehabilitation Services are provided to children/youth to remediate debilitating psycho-social, emotional and behavioral disorders. To provide early intervention, stabilization and development of appropriate 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 include milieu therapy, crisis counseling, regular scheduled counseling and skills training. The purpose of this service is to remediate specific dysfunctions which have been explicitly identified in an individualized written treatment plan that is regularly

LIMITATION ON SERVICES

reviewed and updated. Client centered treatment services may be provided individually or in groups and may include the child's/youth's biological, adoptive or foster family. Treatment is focused upon the needs of the child/youth, not the family unit. These services may be in conjunction with or in support of any other professional treatment services the child/youth may be receiving as required by the diagnosed condition.

The services will include crisis intervention and counseling 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.

Regular scheduled counseling and therapy is provided to remediate specific dysfunctions which have been explicitly identified in the treatment plan.

Skill training is provided to assist the child/youth in the development of appropriate 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.

Milieu therapy refers 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 dysfunctional or maladaptive behaviors and promote their replacement with more developmentally appropriate responses.

Population To Be Served.

The population serviced will be EPSDT eligible children/youth who have primary mental, emotional and behavioral disorders and/or developmental disabilities that prevent them from functioning at developmentally appropriate levels in their home, school, or community. They exhibit such symptoms as drug and alcohol abuse, anti-social behaviors that require close supervision and intervention and structure, sexual behavior problems, victims of severe family conflict, behavioral disturbances often resulting from psychiatric disorders of the parents, medically compromised and developmentally disabled children/youth who are not otherwise served by the State Mental Health Developmental Disability Services Division.

LIMITATION ON SERVICES

Provider Qualifications.

Program Coordinator: Responsibilities include supervision of staff, providing overall direction to the program, planning and coordinating program activities and delivery of services, and assure the safety and protection of children/youth and staff.

The 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 residential facility for care and treatment of children/youth.

Social Service Staff: Responsibilities include Case Management and the development of service plans; individual, group and family counseling; individual and group skills training; assist the Child Care Staff in providing appropriate treatment to children/youth, coordinate services with other agencies; document treatment progress.

The Minimum Qualifications- A Masters Degree with major study in Social Work or a closely allied field and one year of experience in the care and treatment of children/youth, or a Bachelor's Degree with major study in Social Work, psychology, Sociology, or a closely allied field and two years experience in the care and treatment of children/youth.

Child Care Staff: Responsibilities include direct supervision and control of the daily living activities of children/youth, assisting social service staff in providing individual, group and family counseling, skills training, provide therapeutic interventions to children/youth as directed by the individual treatment plans to address behavioral and emotional problems as they arise, monitor and manage the children's/youth's behavior to provide a safe, structured living environment that is conducive to treatment.

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. Child Care are members of the treatment team and work under the direction of a qualified Social Service staff or a Program Coordinator.

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.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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 he in need of such care.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

b. Including such services in a public institution (or district part thereof) for the mentally retarded or

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

17. Nurse-midwife services.

[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided.

18. Hospice care (in accordance with section 1905(o) of the Act.

[X] Provided [ ] No limitations
[X] Provided in accordance with section 2302 of the Affordable Care Act

[X] 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.

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

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.

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

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.

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

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.

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

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:

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a ~~qualified~~ eligible provider (in accordance with section 1920 of the Act).

/ / 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.

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.

State/Territory OREGON

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

[X] Provided [ ] No limitations [X] With limitations*

[ ] Not Provided:

b. Services provided in Religious Nonmedical Health Care Institutions.

[ ] Provided [ ] No limitations [ ] With limitations*

[X] Not Provided:

c. Reserved

d. Nursing facility services for patients under 21 years of age.

[X] Provided [X] No limitations [ ] With limitations*

[ ] Not Provided:

e. Emergency hospital services.

[X] Provided [X] 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.

[X] Provided [ ] No limitations [X] With limitations*

[ ] Not Provided:

*Description provided on Attachment.

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.)

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.

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)

"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.

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)

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.

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)

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.

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)
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.

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)

Delegated Nursing Tasks (continued)

- Oral Suctioning – to prevent aspiration due to gastroesophogeal 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.

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.

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).

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)

Eligible individuals must be assessed for their need for personal care services. Personal care services are limited to 20 hours per month. Individuals whose assessed need exceeds the 20 hour 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 impatient 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.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____Oregon_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitations

Citation (s)	Provision (s)
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: *("All" drugs categories covered under the drug class)* ☐ *("Some" drugs categories covered under the drug class* ☒ *-List the covered common drug categories not individual drug products directly under the appropriate drug class)* *("None" of the drugs under this drug class are covered)* ☐ ☒ (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below) Appetite Stimulants for Anorexia, Cachexia, Wasting ☐ (b) agents when used to promote fertility (see specific drug categories below) ☐ (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____Oregon_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Citation (s)	Provision (s)
	☒ (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below) Cough Preparations/Expectorants Cough & Cold Preps
	☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below) Vitamin K B Complex with Vitamin C Folic Acid Preparations Multivitamins Except Prenatals Water Soluable Vitamins Except Niacin Fat Soluable Vitamins Except Vitamin D
	☒ (f) nonprescription drugs (see specific drug categories below) 1st Generation Antihistamines & Decongestant Combinations Diphenhydramine Antiulcer Preps/Gastrointestinal Preps Non-Narcotic Analgesics
	☐ (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 (see specific drug categories below)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____Oregon_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)

All categories listed above are subject to the 'limitations of Services' and Prior Authorization program as described in Attachment 3.1-A page 5-a,5-b and 5-c or outlined in the approved 1115 Waiver.

Targeted Case Management
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.

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 individualss 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).

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.

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)].

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
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- 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,

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-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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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:

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-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.

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-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;

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-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))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ___Oregon_____

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State: ___Oregon_____

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State: ___Oregon_____

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State: ___Oregon_____

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ___Oregon_____

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Targeted Case Management

Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18

Target Group:
Medicaid eligible individuals that are Substance Abusing Pregnant Women and Substance Abusing Parents of children under age 18, who are identified, through referral from individuals, providers or community agencies, to have alcohol and/or drug addiction issues, but who are not yet ready to actively engage in addiction treatment services.

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) Polk, Yamhill, Linn, Benton, Jackson and Marion.

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;

- 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.
- Evaluation of the capacity of the individual 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 (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))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
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 or conditions that are lacking readiness to engage in active treatment. This experience will demonstrate an understanding of issues relating to substance abuse, as well as needed community supports and linkages that will enable the individual to prepare for treatment. In addition, providers must demonstrate continuous sobriety under a nonresidential or independent living condition for the immediate past two (2) years.

The Department will authorize locally-based agencies that are licensed, certified or have received a letter of approval from the Addictions and Mental Health Division. Individuals may provide these services if verified by an agency holding a letter of approval from the Addictions and Mental Health Division. 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.

These providers must have oversight by a Clinical Supervisor meeting the requirements in Oregon Administrative Rule, in alcohol and other drug treatment programs, certified or licensed by a health or allied provider agency to provide addiction treatment, and have one of the following qualifications:
1. Five years of paid full-time experience in the field of alcohol and other drug counseling; or
2. A Bachelor's degree and four years of paid full-time experience in the social services field, with a minimum of two years of direct alcohol and other drug counseling experience; or
3. A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience.
Providers will have continuing education requirements as specified by the agency providing Clinical Supervision specific to alcohol and other drug treatment.

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.

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))

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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:

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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))

Targeted Case Management-Babies First/CaCoon

Target Group:

Targeted case management (TCM) services will be provided to Medicaid eligible infants and preschoolers through four years of age who have risk factors (listed below) for poor health outcomes. TCM services will be provided to Medicaid eligible children up to age 21, who have a diagnosis or very high risk factor listed below.

Medical Risk Factors (Birth through 4 yrs)	**Diagnosis** (Birth – to 21 yrs)
Drug exposed infant	Heart Disease
Alcohol Exposed infant	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
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 exposure	Positive newborn blood screen
Suspect hearing loss:	HIV, seropositive conversion
Other risk factors not listed	Visual Impairment
Social Risk Factors	**Very High Medical Risk Factors**
Maternal Age 16 years or less	Intraventicular hemorrhage (grade III or IV) or periventricular leukomalacia (PVL) Or chronic subdurals
Parents with developmental disabilities or intellectual impairment	Perinatal asphyxia accompanied by seizures
Parental alcohol or substance abuse	Seizure disorder

Social Risk Factors	**Very High Medical Risk Factors**
At-risk caregiver	Oral-motor dysfunction requiring specialized feeding program (including gastrostomy)
Concern of parent/provider	Chronic lung disorder
Parent with limited financial resources	Suspect neuromuscular disorder
Parent with history of mental illness	**Developmental Risk Factors**
Parent with child welfare history	Developmental Delay
Parent with domestic violence history	**Other**
Other evidence based social risk factors	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.

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:

- Evaluation of individual's history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and completing related documents.

- 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.
- 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:
- Specifies the goals and actions 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, 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 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 can be performed monthly or as needed and could 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 individual's, that 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:

Babies First/CaCoon Targeted Case Managers may be an employee of a Local County Health Department, or other public or private agency contracted by a Local County Health Department. The case manager must be:

- a licensed registered nurse with one year of experience in community health, public health, child health nursing;
- be a Community Health Workers, Family Advocates or Promotoras 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 2 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 Title V MCH 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 Title V Statewide MCH Data System or provide another statewide computerized tracking and monitoring 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.

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 §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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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

(Reserved for future use)

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

(Reserved for future use)

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

(Reserved for future use)

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

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.

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

(Reserved for future use)

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

(Reserved for future use)

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

(Reserved for future use)

CASE MANAGEMENT SERVICES

Section 1915(g) of the Social Security Act is the authority for this amendment.

Target Group: (Section A of Supplement 1 State Plan Preprint)

Medicaid eligible parents age 14 and over who receive Aid to Families with Dependent Children (AFDC) benefits.

Definition of Services: (Section D of Supplement 1, State Plan Preprint)

Case management services are those covered services needed by the target group to identify barriers to self-sufficiency, identify the medical, social, educational and other services necessary to remove those barriers, and facilitate access to those services. Case management includes screening and assessment, plan development, referrals to service provider, evaluation of the appropriateness of the training, service coordination, monitoring of the client and problem resolution.

1. Screening and Assessment: The case manager gathers information to identify the client's strengths, interests, vocational aptitudes and any services needed to remove barriers to self-sufficiency. It includes collecting information, testing abilities and aptitudes, evaluating the tests, informal observations and information from service providers. Assessment first occurs at intake and is an ongoing, continuous collection of information to evaluate the effectiveness of support services and monitor the client's progress.

2. Case Plan Development: The case manager develops a case plan, consisting of a written outline of employment and training goals for a client to attain self-sufficiency. A plan may include activities to prepare the client for employment, services to remove barriers to employment, training and job search. The plan also includes which support service payments will be needed.

3. Referrals to Service Providers: The case manager will send clients to service providers for medical, social, educational and other services.

4. Evaluation of Appropriateness of Training: The case manager evaluates the appropriateness of training offered by a services provider. The training must meet the

needs of the client as specified in the case plan.

5. Service Coordination: The case manager will coordinate the delivery of services to the client by the service provider and assist the client in getting the needed services.

6. Monitoring of the Client: The case manager will monitor the client's success in completing the activities called for in the case plan.

7. Problem Resolution: The case manager will resolve problems between the client and the service provider.

Qualification of Providers: (Section E of Supplement 1, State Plan Preprint)

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:

1. 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.

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.

2. 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.

Targeted Case Management
CAF Self sufficiency

(Reserved for future use)

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

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_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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;

(h)

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

Stat/Territory: ___OREGON_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Targeted Case Management- Healthy Homes Program

Qualifications of providers (Cont)

(i) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program;
(j) 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 Standford 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_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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. X 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 in regulations). 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. X 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.

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

Regular Post Eligibility

1. __X__ 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._X_The following standard included under the State plan (check one):

(a) _X____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.

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

6._____ The amount is determined using the following formula: The amount allowed in Sec. 1924 of the Act _____
7._X___ Not applicable (N/A)

(C.) Family (check one):
1._X_ 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.

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

(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.

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.____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. X 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. X 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:

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

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._X_ Other (please describe)

The acute care portion of the UPL was based on the fee-for service claims data and the managed care encounter data. The long-term care portion of the UPL was based on fee-for-service claims data and some costs that on not in the MMIS database. Once the UPL was developed each portion was set at different percentages of the UPL. See Attachment to Supplement 2 to Attachment 3.1-A for complete description of the rate methodology.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Price Waterhouse Coopers, 333 Market St, San Francisco did the work on the medical portion of the UPL and the initial work on the long-term care portion of the UPL.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

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

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.

PACE Rate Methodology and Upper Payment Limit Calculation

The following information is organized and is consistent with the format of the resource document which reflects the PACE: Upper Payment Limit and Capitation Rates development for the current PACE Contract. The Upper Payment Limit and PACE Capitation rates are developed and submitted by Oregon DHS Actuarial Service Unit. The Upper Payment Limits calculated for the PACE program are done in a manner that provided the best estimate of the per capita cost of providing comparable services to the PACE-eligible population if those eligibles were not enrolled in PACE. PACE-eligibles are persons living in PACE service area who are age 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 (which excludes SLMB and QMB-only who are not Medicaid eligible and Medically Needy individuals)

Acute Care:
The assumptions used in calculating the PACE acute care UPLs were the same as those used to develop the Oregon Health Plan per capita costs. The methods 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 have been modified for the PACE-eligible population and contract period.

1. A data file was created to identify the PACE-eligible population excluding PACE enrollees. This file was matched against the OHP eligibility file to determine enrollment periods in Fee-for-service or managed care for this population.
2. The resulting eligibility information was matched against the claim or encounter data for the PACE-eligible population.

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

PACE Rate Methodology and Upper Payment Limit Calculation(cont)

3. The data was summarized to obtain total charges (encounter data) and total paid amounts (fee-for-service) by service category and demographic groupings.
4. The resulting eligibility information was used to develop member months of eligibility within each delivery system which were used as the denominator in the calculation of per capita costs. Appropriate adjustments were made for missing data and budget issues.
5. Trend rates were developed for various service categories, eligibility groups, and delivery systems.
6. Cost-to-charge ratios by service category were calculated and applied to encounter data for services that are provided through managed care plans. Since the cost information for encounter data is charges not paid claims, the cost-to charge ratios were used to convert this information to a cost basis.
7. Total projected costs per member per month were calculated for each service delivery arrangement and demographic grouping. PMPM amounts, representing unadjusted UPLs were then calculated from a blend of the managed care and FFS PMPMs. The weights used to blend the PMPMs were the PACE eligible member months in each delivery system.

Long Term Care:

The LTC component of the PACE UPL was developed in a similar manner to the acute care UPL. However, because the LTC services for the PACE-eligible population are paid on a fee-for service basis the rate development is restricted to experience in that delivery system. Additionally, certain services appropriate for inclusion in the UPL, but not included in the MMIS system, were identified and their costs were included in the calculation. These included client contribution paid directly by the individuals to providers, including payments to nursing homes, assisted living and residential care facilities and to adult foster homes. Home-delivered meals are another cost category that is not reported through MMIS data. These costs were allocated into LTC service priority level groupings.

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

PACE Rate Methodology and Upper Payment Limit Calculation (cont)

The general process by which the LTC UPL was calculated is as follows:

1. The data file containing identification information and dates of eligibility for PACE-eligible individuals in PACE service area.is created. PACE participants were excluded from this population.
2. This eligibility information was matched against the LTC claims data to create the claims experience for the PACE-eligible population.
3. Claim data was summarized to obtain information on total amounts for the data period by service category and LTC service priority level groupings.
4. The PACE eligibility information is used to develop member months of eligibility. These figures were then used as the denominator in the calculation of per capita costs.
5. Trend rates were developed for various service categories.
6. Total projected LTC costs PMPM were calculated for each demographic grouping.

Final Upper Payment Limits

The per capita costs reflect the expected claims costs per person per month under each delivery system, plus an administrative allowance. Since PACE enrollees can come from either fee-for-service or managed care, these costs are blended based on the distribution of PACE eligible member months between the delivery systems. Smoothing techniques were applied to the UPLs to mitigate the effects of small populations in certain cohorts. A percentage of each UPL is used for the LTC and acute care portion of the PACE rate. The PACE rate is currently paid by four eligibility categories; Blind & Disabled (age 55-64) with and without Medicare and Old Age Assistance (age 65+) with and without Medicare.

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 they meet specified performance measures for the reporting period. The state ensures the combined PMPM PACE capitation rate and the supplemental PMPM performance incentive payment will be less than the UPL for the eligibility category.

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

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.

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

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.

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

v. 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.

vi. 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.

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

- 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 disneroll the participant from the program.

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

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.

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.

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

viii. Geographic Limitations and Comparability

A. __**X**___ 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. __**X**_ 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. __**X**__ 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.

ix. Assurances

A. The State assures that there are traditional personal assistance services, comparable in amount, duration and scope, to self-directed personal assistance 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

1915(j) Self-Directed Personal Assistance Services

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.

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

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.

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

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.

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

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.

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.

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

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.

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

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.

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

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.

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

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.

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

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.

xii. 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.

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

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.

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

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.

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

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.

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

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.

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

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.

xiii. Qualifications of Providers of Personal Assistance

A. __**X**__ 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.

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

xiv. Use of a Representative

A. __**X**__ 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.

xv. Permissible Purchases

A. __**X**__ 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.

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

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. __X__ 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.

§1915(i) HCBS State plan Services
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 service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Home Based Habilitation, HCBS Behavioral Habilitation, HCBS psychosocial Rehabilitation for persons with CMI

2. 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 *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	●	Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	Addictions and Mental Health Division (AMH)
○	The State plan HCBS benefit is operated by *(name of agency)*		
	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.		

§1915(i) HCBS State plan Services
State/Territory: Oregon

3. 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	☑	☐	☐	☐
2 State plan HCBS enrollment managed against approved limits, if any	☐	☐	☐	☐
3 Eligibility evaluation	☑	☑	☐	☑
4 Review of participant service plans	☑	☐	☑	☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐	☑	☐
7 Qualified provider enrollment	☑	☐	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Medicaid Agency above is AMH

Other State Operating Agency is Seniors and People with Disabilities who determine Medicaid eligibility as a part of function #3.

Local Non-State Entity is an EQRO that makes the clinical determination that the individual meets the eligibility criteria set forth under State Plan Needs-based HCBS Eligibility Criteria.

Contracted Entity is the Mental Health Organization who perform functions #4, 6 and 11.

(By checking the following boxes the State assures that):

4. ☑ **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):*

AMH assures that appropriate safeguards against conflicts of interests have been implemented in the process of eligibility determinations and independent assessments. Individuals participating in the eligibility determination will be paid staff of a external quality review organization. As such, they are independent of the financial implications of their determination.

Assessments and plans of care will be completed by staff of State Plan HCBS providers who meet the qualifications outlined as a Qualified Mental Health Professional (Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or 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 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 practice. AMH values having information gained during treatment be reflected in ongoing assessments and plans of care. As a first level of oversight, Mental Health Organizations must recommend the services on the plan as medically appropriate. Because there is the appearance that a conflict of interest may exist in having the provider determine which services the individual needs to be successful, AMH has created a measurement as part of the Quality Management Strategy to ensure services requested are appropriate based on the individual's assessment.

This measure can be found on the Quality Management Strategy as Assurance 2 (Service Plan) Sub Assurance d.

5. ☑**Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

6. ☑**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.

7. ☑ **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	1/2012	1/2013	3000
Year 2			
Year 3			
Year 4			
Year 5			

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.

Financial Eligibility

1. ☑**Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

●	The State does not provide State plan HCBS to the medically needy.	
○	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

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*):

○	Directly by the Medicaid agency
●	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	External Quality Review Organization

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):*

Qualified Mental Health Professional
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
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 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 practice.

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 External Quality Review Organization (EQRO) will review the necessary clinical information (including assessment, service plan and plan of care and other relevant documentation), submitted by a staff employed by the Mental Health Organization (MHO), Local Mental Health Authority (LMHA) or their subcontractor, to make the 1915(i) eligibility determination. The Plan of Care reviewed includes an estimated number of hours of personal care assistance the individual requires.

General Medicaid financial eligibility determinations occur within 45 days; presumptive eligibility is utilized when appropriate. State Plan Needs-based HCBS Eligibility determinations will be made by the contracted certified External Quality Review Organization. This review will be conducted within the EQRO office as a paper review including a review of all necessary clinical records such as assessments and services and supports plans as necessary. The EQRO will provide a determination within 5 working days once all necessary documentation has been submitted.

4. ☑ **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 person needs daily Assistance of at least 1 hour per day to perform at least two Personal Care Services specified in OAR 309-016-0695.

5. ☑ **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/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The person needs daily Assistance of at least 1 hour per day to perform at least two Personal Care Services specified in OAR 309-016-0695 and does not meet criteria established for 1915(c) Waiver services.	**Nursing Home Level of Care.** OAR 411-015 Priority of Paid Services. Eligibility for this level of care and the corresponding HCBS waiver requires that: *Persons have a need for assistance or full assistance in activities of daily living which are determined by a standardized assessment tool which ranks needs according to acuity on a scale of 1-18. Currently the Division is serving OSIPM eligible persons who are 18 or over and have needs at Levels 1-13. A person at Level 1 would need full assistance in 4 ADLs; mobility, eating, elimination and cognition while a person at Level 13 would only need assistance with elimination.	"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 mental retardation, 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: • Originates before the individual attains the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18; and	**Criteria for Long Term Psychiatric Inpatient Care** • Primary DSM Diagnosis is severe psychiatric disorder • Documented need for 24-hour hospital level medical supervision • At least one of the following conditions is met: o Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications. o. Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days)

§1915(i) HCBS State plan Services
State/Territory: Oregon

Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
	• Persons who meet this criteria and who have mental illness or mental retardation or developmental disabilities are subject to an additional screening process to ensure compliance with federal PASRR standards (OAR 411-070 PASRR), *State Plan Amendment limitations* for serving persons with mental illness and to identify the best HCBS waiver for persons with MR or DD. • Individuals who are age 17 or younger and reside in a nursing facility are eligible for nursing facility services only, subject to PASRR limitations. They are not eligible to receive waivered services.	• 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; and • The condition or impairment must not be primarily attributed to mental or emotional disorders, sensory impairments, substance abuse, personality disorder, learning disability or Attention Deficit Hyperactivity Disorder (ADHD). OAR 411-320-0020 or; • "Mental Retardation" defined as IQ's under 70 existing concurrently with significant impairments in adaptive behavior that are manifested during the developmental period, prior to 18 years of age.	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: ▪ 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.

Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		Individuals of borderline intelligence, IQ's 70-75, may be considered to have mental retardation if there is also significant impairment of adaptive behavior as diagnosed and measured by a qualified professional. The adaptive behavior must be primarily related to the issues of mental retardation. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision. OAR 411-320-0020	▪ The OHP Member has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment. ▪ Failure of intensive extended care services evidenced by documentation in the Clinical Record of: ○ 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

Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
			management problems within the local Acute Inpatient Hospital Psychiatric Care unit. • 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

(By checking the following boxes the State assures that):

6. ☑ **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **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).

8. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Individuals may receive State Plan HCBS services while residing in any community-based living situation including independent living situations, supported housing, adult foster home, residential treatment facility or home provided the individual meets the established criteria for eligibility. Individuals residing in a program licensed as a Secured Residential Treatment Facility will not be offered services under the 1915(i) Home and Community-based Services State Plan Option.

Rule requirements of Residential Treatment Facilities (6 or more people) and Homes (five or fewer people) include:

- An accessible outdoor area is required and will be made available to all residents. A portion of the accessible outdoor area will be covered and have an all weather surface, such as a patio or deck.
- Storage for a reasonable amount of resident belongings beyond that available in resident sleeping rooms will be provided;
- Privacy is offered in the residents sleeping rooms which require:
    - A limit of one or two residents;
    - A clothes closet;
    - Exterior window(s); sleeping room windows will be equipped with curtains or blinds for privacy and control of light;
    - Residents will be allowed to use their own furniture within space limitations;
- Common Use Rooms. The facility will include lounge and activity area(s) for social and recreational use, exclusively by residents, staff and invited guests;
- Kitchen
- Dining Area. A separate dining room or area where meals are served will be provided for the exclusive use of residents, employees, and invited guests
- Telephones. The facility will provide adequate access to telephones for private use by residents
- Services and activities; residents will be encouraged to care for their own needs to the extent possible. All services and activities will be provided in a manner that respects residents' rights, promotes recovery and affords personal dignity
    - Assistance and support, as necessary, to enable residents to meet personal hygiene and clothing needs;
    - Laundry services, which may include access to washer(s) and dryer(s) so residents can do their own personal laundry;
    - Activities and opportunities for socialization and recreation both within the facility and in the larger community;
    - Assistance with community navigation and transportation arrangements;

- Assistance with money management, where requested by a resident; and
- Assistance with acquiring skills to live as independently as possible;

- House Rules. The facility will develop reasonable house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies and smoking. The house rules will be consistent with resident rights as delineated in OAR 309-035-0155. House rules will be posted in an area readily accessible to residents. House rules will be reviewed and updated, as necessary. Residents will be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective.

Additionally, the kitchen is available for use by individuals whose symptoms do not prevent them from having unrestricted access to the kitchen. Individuals may choose to prepare their own meals or snacks at a timeline of the individuals choosing unless limited by the House Rules. "Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan." (OAR 309-040-0305)

Rule requirements of Adult Foster Homes (five or fewer people) include:

- "Homelike Environment" means an Adult Foster Home settings, which promotes the dignity, safety, independence, security, health and comfort of residents through the provision of personalized care and services to encourage independence, choice, and decision making of the residents;
- Outdoor Areas. An accessible outdoor area is required and will be made available to residents. A portion of the outdoor area will be covered and have an all weather surface, such as a patio or deck.
- Storage Areas. Storage for a reasonable amount of resident personal belongings beyond that of the resident sleeping room will be made available;
- Bathrooms. No person will walk through another person's bedroom to get to a bathroom and will have barrier-free access to toilet and bathing facilities with appropriate fixtures;
- Bedrooms. All resident sleeping rooms will include a minimum of 70 square feet of usable floor space for each resident or 120 square feet for two residents and have no more than two persons per room and allow for a minimum of three feet between beds. In determining maximum capacity, consideration will be given to whether children over the age of five have a bedroom separate from their parents. Each bedroom will have sufficient separate, private dresser and closet space for each resident's clothing and personal effects, including hygiene and grooming supplies. Residents will be allowed to keep and use reasonable amounts of personal belongings, and to have private, secure storage space. Drapes or shades for windows will be in good condition and allow privacy for residents;

- Common Use Rooms. There will be at least 150 square feet of common space, and sufficient comfortable furniture in the Adult Foster Home to accommodate the recreational and socialization needs of the occupants at one time. Common space will not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit.
- Kitchen
- Telephones. A telephone will be available and accessible for residents' use for incoming and outgoing calls in the Adult Foster Home. Limitations on the use of the telephone by residents are to be specified in the written house rules. Individual restrictions must be specified in the individual residents Personal Care Plan. In all cases, a telephone will be accessible to residents for outgoing calls (emergencies) 24 hours a day
- Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels and washcloths;
- Self-administration of medication

- Bill of rights: Residents of adult foster homes have the following rights. Providers shall guarantee these rights and help residents exercise them. The provider shall post a copy of the Residents' Bill of Rights in the entry or other equally prominent place in the adult foster home. The Residents' Bill of Rights states that each resident of an adult foster home has the right to:

(1) Be treated as an adult, with respect and dignity.
(2) Be informed of all resident rights and all house rules.
(3) Be encouraged and assisted to exercise legal rights, including the right to vote.
(4) Be informed of the resident's medical condition and the right to consent to or refuse treatment.
(5) Receive appropriate care and services, and prompt medical care as needed.
(6) A safe and secure environment.
(7) Be free from mental and physical abuse.
(8) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner.
(9) Complete privacy when receiving treatment or personal care.
(10) Associate and communicate privately with any person the resident chooses.
(11) Send and receive personal mail unopened.
(12) Participate in activities of social, religious and community groups.

(13) Have medical and personal information kept confidential.
(14) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space.
(15) Manage the resident's own money and financial affairs unless legally restricted.
(16) Be free from financial exploitation. The provider may not charge or ask for application fees or nonrefundable deposits and may not solicit, accept or receive money or property from a resident other than the amount agreed to for services.
(17) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home.
(18) Not to be transferred or moved out of the adult foster home without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge a resident only for medical reasons including a medical emergency described in ORS 443.738 (11)(b), or for the welfare of the resident or other residents, or for nonpayment.
(19) Be free of discrimination in regard to race, color, religion, sex, sexual orientation or national origin.
(20) Make suggestions and complaints without fear of retaliation
Additionally, the kitchen is available for use by individuals whose symptoms do not prevent them from having unrestricted access to the kitchen. Individuals may choose to prepare their own meals or snacks at a timeline of the individuals choosing unless limited by the House Rules. "Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan." (OAR 309-035-0105)

Individuals residing in adult foster homes have unrestricted access to the community and a choice of roommates when more than one individual shares the same bedroom.

(iii) Services provided to individuals residing in any residential setting that meets the definition of an Institute for Mental Disease as defined in 42CFR435.1010 shall not be eligible for Federal matching funds.

9. **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. 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). (*Specify target group(s)*):

Due to a chronic mental illness as defined in Oregon Revised Statute 426.495.

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 is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☑ Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

Person-Centered Planning is a core value in the provision of services and supports. Oregon has defined "person-directed" as "the individual, and others involved in supporting the treatment and recovery of the individual, are actively involved in assessment, planning and revising services and supports and intended outcomes. Individuals are empowered through this process to regain their health, safety and independence to the greatest extent possible and in a manner that is holistic and specific to the individual, including culturally, developmentally, age and gender appropriate." Oregon Administrative Rules require the clinical record to include documentation of collaboration between the individual and provider in the development of the services and supports plan. Individuals that meet the criteria for HCBS services are free to choose their provider from all authorized, available and willing providers. Individuals are encouraged to participate in the planning and delivery of the services and supports available to them and change providers at any time.

3. **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 physical and mental needs for HCBS. *(Specify qualifications):*

Qualified Mental Health Professional (QMHP)
Qualifications for a **QMHP** are:
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
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 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 practice.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Qualified Mental Health Professional (QMHP)
Qualifications for a **QMHP** are:
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
Graduate degree in recreational, art, or music therapy; or
Bachelor's degree in occupational therapy and be licensed by the State of Oregon;

AND

4. Responsibility for Plan of Care Development(Cont).

Education and experience which 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 practice.

All services contained within the Individual Services and Supports Plans are recommended by a physician or other licensed healthcare practitioner. A licensed healthcare practitioner means 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 (including but not limited to: Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and Licensed Professional Counselor)

5. Supporting the Participant in Plan of Care Development. 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 plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

OAR 309-032-1530 **Individual Service and Support Planning and Coordination**

(C) Engagement and agreement of the individual, and family if applicable, in the development of the ISSP.

(d) Individuals, and family members, as applicable, must collaboratively participate in the development of the ISSP.

(e) Providers must fully inform the individual and guardian when applicable, of the proposed services and supports, in developmentally and culturally appropriate language, and give the individual and guardian when applicable, a written copy of the ISSP.

6. 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 plan of care):*

Participants will be offered a choice of authorized, available and willing providers who can meet the needs and provide the individualized services identified in the participants plan of care. This process will be documented in the clinical record. The individual may work with the MHO directly without the direct involvement of the provider to identify appropriate residential options.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

Providers are required to receive prior authorization for Rehabilitative Mental Health Services and Personal Care services. Prior Authorization requests and Plans of Care are submitted to AMH and all are reviewed for clinical appropriateness based on the required supporting documentation submitted along with the request. A provider can not receive reimbursement for a claim if the approved Prior Authorization or Plan of Care has not been entered into the system.

8. Maintenance of Plan of Care 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):*

☑	Medicaid agency -AMH	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	Mental Health Organization			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**Home Based Habilitation**
Service Definition (Scope)*:* Habilitation services are designed to help the individual attain or maintain their maximal level of physical, mental, and social functioning and independence. Services are provided in order to assist an individual to acquire, retain or improve skills in the following areas: assistance with activities of daily living, cooking, home maintenance, recreation, community inclusion and mobility, money management, shopping, community survival skills, communication, self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.	
Home Based Habilitation is based on each individual assessment and individual services and support plan to deliver a combination of the following services: o Assistance w. IADL and ADLs o Staff as needed to support the individual's recovery o Assistance in obtaining Non Medical Transportation o Skill development (ADL's, cooking, home maintenance, recreation, community mobility, money management, shopping, community survival skills, educational support) and may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Participants requiring skills development, behavioral support, activity therapy or supports for the maintenance of psychosocial skills on a 24/7 basis would be authorized to receive Home Based Habilitation from Providers who meet or have employees who meet qualifications to deliver Habilitation.	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

§1915(i) HCBS State plan Services
State/Territory: Oregon

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Qualified Mental Health Professional			Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or 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 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 practice.
Qualified Mental Health Associate			"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) 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 the scope of his or her practice.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Peer Services Support Specialist			An Individual who has successfully completed training through a curriculum qualified by AMH and (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.
Recovery Assistant			(1) 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. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007. (3) A qualified provider 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.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Recovery Assistant (cont)			(4) A qualified provider must be authorized to work in the United States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. (8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) 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. enrolled as PCA with individual provider number (9) Provider must not be included on any US Office of Inspector General Exclusion lists

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):*
QMHP	Local Mental Health Authority and Mental Health Organization	**Every three years**

§1915(i) HCBS State plan Services
State/Territory: Oregon

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):*
QMHA	Local Mental Health Authority and Mental Health Organization	**Every three years**
Peer Services Support Specialist	Local Mental Health Authority and Mental Health Organization	**Every three years**
Recovery Assistant	Local Mental Health Authority and Mental Health Organization	**Every three years**
Adult Foster Home	Addictions and Mental Health Division	**Every three years**
Residential Treatment Facility/Home	Addictions and Mental Health Division	**Every two years**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	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:	**HCBS Behavioral Habilitation**
Service Definition (Scope)*:* Services intended to improve and maintain the individual's acceptance in their residence and prevent unnecessary changes in residence	
Services include o Behavior Support o Training and Education- Psychosocial skills o Activity Therapy and may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.	
Additional needs-based criteria for receiving the service, if applicable (specify):	
Authorized via annual individualized plan of care as either; Daily ongoing service to be provided directly by a Home Based Habilitation provider or their employees who meet the qualifications below or an; Episodic or time limited service provided by a Qualified Provider. Persons 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.	

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
QMHP			Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or 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 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 practice.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
QMHA			"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) 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 the scope of his or her practice.
Peer Services Support Specialist			An Individual who has successfully completed training through a curriculum qualified by AMH and (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.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Recovery Assistant			1) 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. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007. (3) A qualified provider 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. (4) A qualified provider must be authorized to work in the Unit States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. (8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Recovery Assistant			(b) Cont- 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. enrolled as PCA with individual provider number (9) Provider must not be included on any US Office of Inspector General Exclusion lists
Adult Foster Home			Rule requirements of Adult Foster Homes (five or fewer people) include: • "Homelike Environment" means an Adult Foster Home settings, which promotes the dignity, safety, independence, security, health and comfort of residents through the provision of personalized care and services to encourage independence, choice, and decision making of the residents;

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			Outdoor Areas. An accessible outdoor area is required and will be made available to residents • A portion of the outdoor area will be covered and have an all weather surface, such as a patio or deck. • Storage Areas. Storage for a reasonable amount of resident personal belongings beyond that of the resident sleeping room will be made available; • Bathrooms. No person will walk through another person's bedroom to get to a bathroom and will have barrier-free access to toilet and bathing facilities with appropriate fixtures; • Bedrooms. All resident sleeping rooms will include a minimum of 70 square feet of usable floor space for each resident or 120 square feet for two residents and have no more than two persons per room and allow for a minimum of three feet between beds. In determining maximum capacity, consideration will be given to whether children over the age of five have a bedroom separate from their parents.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			Each bedroom will have sufficient separate, private dresser and closet space for each resident's clothing and personal effects, including hygiene and grooming supplies. Residents will be allowed to keep and use reasonable amounts of personal belongings, and to have private, secure storage space. Drapes or shades for windows will be in good condition and allow privacy for residents; • Common Use Rooms. There will be at least 150 square feet of common space, and sufficient comfortable furniture in the Adult Foster Home to accommodate the recreational and socialization needs of the occupants at one time. Common space will not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit. • Kitchen • Telephones. A telephone will be available and accessible for residents' use for incoming and outgoing calls in the Adult Foster Home. Limitations on the use of the telephone by residents are to be specified in the written house rules. Individual restrictions must be specified in the individual residents Personal Care Plan. In all cases, a telephone will be accessible to residents for outgoing calls (emergencies) 24 hours a day

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			• Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels and washcloths; • Self-administration of medication • Bill of rights: Residents of adult foster homes have the following rights. Providers shall guarantee these rights and help residents exercise them. The provider shall post a copy of the Residents' Bill of Rights in the entry or other equally prominent place in the adult foster home. The Residents' Bill of Rights states that each resident of an adult foster home has the right to: (1) Be treated as an adult, with respect and dignity. (2) Be informed of all resident rights and all house rules. (3) Be encouraged and assisted to exercise legal rights, including the right to vote. (4) Be informed of the resident's medical condition and the right to consent to or refuse treatment.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			(5) Receive appropriate care and services, and prompt medical care as needed. (6) A safe and secure environment. (7) Be free from mental and physical abuse. (8) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner. (9) Complete privacy when receiving treatment or personal care. (10) Associate and communicate privately with any person the resident chooses (11) Send and receive personal mail unopened. (12) Participate in activities of social, religious and community groups. (13) Have medical and personal information kept confidential. (14) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space. (15) Manage the resident's own money and financial affairs unless legally restricted.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			(16) Be free from financial exploitation. The provider may not charge or ask for application fees or nonrefundable deposits and may not solicit, accept or receive money or property from a resident other than the amount agreed to for services. (17) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home. (18) Not to be transferred or moved out of the adult foster home without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge a resident only for medical reasons including a medical emergency described in ORS 443.738 (11)(b), or for the welfare of the resident or other residents, or for nonpayment. (19) Be free of discrimination in regard to race, color, religion, sex, sexual orientation or national origin. (20) Make suggestions and complaints without fear of retaliation Additionally, the kitchen is available for use by individuals whose symptoms do not prevent them from having unrestricted access to the kitchen. Individuals may choose to prepare their own meals or snacks at a timeline of the individuals choosing unless limited by the House Rules.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			"Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan." (OAR 309-035-0105) Individuals residing in adult foster homes have unrestricted access to the community and a choice of roommates when more than one individual shares the same bedroom.

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):*
QMHP	Local Mental Health Authority and Mental Health Organization	**Every Three Years**
QMHA	Local Mental Health Authority and Mental Health Organization	**Every Three Years**
Adult Foster Home	Addictions and Mental Health Division	**Every Two Years**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	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:	**HCBS Psychosocial Rehabilitation for Persons w. CMI**
Service Definition (Scope): Rehabilitative Mental Health Services are medical or remedial services recommended by a physician or other practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible.	

Treatments as listed in the AMH Medicaid Rehabilitative Service Procedure Codes and Reimbursement Rates Table include:

- Comprehensive Medication Services (LMP)
- Individual Therapy
- Group Therapy
- Family Therapy
- Psychiatric Skills Training
- Psychiatric Activity Therapy
- Behavioral health counseling therapy
- Community Psychiatric Supportive Treatment

and may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Participants requiring skills development, behavioral support, activity therapy or supports for the maintenance of psychosocial skills on a 24/7 basis would be authorized to receive Home Based Habilitation from Providers who meet or have employees who meet qualifications to deliver Habilitation.

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
QMHP			Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or 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 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;

§1915(i) HCBS State plan Services
State/Territory: Oregon

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
QMHP (Cont)			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 practice.
QMHA			"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) 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 the scope of his or her practice.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Peer Services Support Specialist			An Individual who has successfully completed training through a curriculum qualified by AMH and (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.

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):*
QMHP,	AMH, Local Mental Health Authority, and Mental Health Organization	**Every three years**
QMHA	AMH, Local Mental Health Authority, and Mental Health Organization	**Every three years**
Peer Services Support Specialist	Local Mental Health Authority, and Mental Health Organization	**Every three years**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

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) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) 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):*

Using a process set in State Plan HCBS (i) Plan OARs, payments for Home Based Habilitation will be made to a relative of the participant only if they a) meet all necessary Provider Qualifications as specified in licensing and other relevant OARs b) are enrolled as a Medicaid provider and have a history of providing the Habilitation service to other HCBS waiver recipients or State Plan HCBS participants and c) there are no alternative Habilitation resources available to meet the participants needs as defined in their plan of care. Case management monitoring will be increased and ongoing attempts to provide the service in an alternative setting will be part of the participants' service plan. As always the planning process is a collaborative one including the direct opinion of the service recipient so any concerns about the service provider, relative or not, is documented and may be directly discussed with the MHO or LMHA at the individual's request.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

⦿	The State does not offer opportunity for participant-direction of State plan HCBS.
○	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.
○	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. *(Specify criteria):*

2. 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):*

3. 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):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	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. (*Specify the areas of the State affected by this option*):

4. 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
	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. 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):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

○	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**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.
	☐	**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). (*Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, 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 plan of care):*
	Expenditure Safeguards. *(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):*

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

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.

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.

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.

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-

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.

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.

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-

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:

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.

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled

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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 XlX 0F 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.

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.

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 CRF 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).

TRANSPLANT SERVICES

1. a. All transplants require prior authorization, except kidney and cornea transplants. Kidney and cornea transplants require prior authorization only if performed out-of-state. Evaluations for possible transplants also require prior authorization separate from the prior authorization for the actual transplant.

   b. An emergency transplant is one in which medical necessity requires that a covered transplant be performed less than 5 days after determination of the need for a transplant, and, upon review, all transplant criteria are met.

   c. Transplant services are provided for eligible clients when covered under the client's benefit package, covered by the Health Services Commission's Prioritized List of Health Services, and OMAP transplant criteria are met.

   d. Prior authorization requests for all covered transplants must be initiated by the client's in-state referring physician.

2. The following types of transplants and transplant-related procedures are covered under the Medical Assistance program:

   (a) Bone Marrow, Autologous and Allogeneic,
   (b) Bone Marrow Harvesting and Peripheral Stem Cell Collection, Autologous,
   (c) Cord blood, Allogeneic,
   (d) Cornea,
   (e) Heart,
   (f) Heart-Lung,
   (g) Kidney,
   (h) Liver,
   (i) Liver-Kidney,
   (j) Simultaneous Pancreas and Kidney transplants, and Pancreas after Kidney transplants,
   (k) Peripheral Stem Cell, Autologous and Allogeneic,
   (l) Single Lung,
   (m) Bilateral Lung,
   (n) Any other transplants the Health Services Commission and the Oregon Legislature determine are to be added to the Prioritized List of Health Services.

3. Non-Covered Transplant Services

The following types of transplants are not covered by the Oregon Medical Assistance program:

(a) Any transplants not listed in Section (2).

(b) Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

(c) Transplants that are considered experimental or investigational, or which are performed on an experimental or investigational basis, as determined by OMAP.

4. Transplant Centers

Transplant services will be reimbursed only when provided in a transplant center which provides quality services, demonstrates good patient outcomes and compliance with all OMAP facility criteria. The transplant center must have provided transplant services for a period of at least two years and must have completed a minimum of 12 cases in the most recent year. The patient and graft survival rates must be equal to or greater than the appropriate standard indicated in this rule.

(a) An experienced and proficient transplant team and a well established transplant support infrastructure at the same physical location as the transplant service is required for transplant services rendered to OMAP clients. OMAP transplant center criteria must be met individually by a facility to demonstrate substantial experience with the procedure.

(b) A transplant facility is required to report to OMAP, within a reasonable period of time, any significant decrease in its experience level or survival rates, the departure of key members of the transplant team or any other major changes that could affect the performance of transplants at the facility. Changes from the terms of approval may lead to withdrawal of OMAP approval for coverage of transplants performed at the facility.

(c) Fully Capitated Health Plans that contract with non-OMAP contracted transplant facilities must require that the transplant centers meet at a minimum the above transplant center criteria, and develop and use appropriate transplant facility criteria to evaluate and monitor for quality services at the transplant facility.

(d) Transplant centers which have less than two years experience in solid organ transplant may be reimbursed, at OMAP's discretion, for allogeneic or autologous bone marrow transplants upon completion of two years of experience in bone marrow transplantation with patient survival rates equal to or exceeding those defined in Section (5) below.

5. Standards for Transplant Centers:

(a) Heart, heart-lung and lung transplants:

(1) Heart: one-year patient survival rate of at least 80 %.

(2) Heart-lung: one-year patient survival rate of at least 65 %.

(3) Lung: one-year patient survival rate of at least 65 %.

(b) Bone Marrow (autologous and allogeneic), Peripheral Stem Cell (autologous and allogeneic), and cord blood (allogeneic) transplants:

(1) one-year patient survival rate of at least 50 %.

(c) Liver and liver-kidney transplants:

(1) one-year patient survival rate of at least 70 % and a one-year graft survival rate of at least 60 %.

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants:

(1) one-year patient survival rate of at least 90 % and one-year graft survival rate of at least 60 %.

(e) Kidney transplant:

(1) one-year patient survival rate of at least 92% and one-year graft survival rate of at least 85%.

6. Selection of transplant centers by geographic location:

(a) If the services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers.

(b) Out-of-state centers will be considered only if:

(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) it would be cost effective as determined by OMAP. 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.

CRITERIA FOR TRANSPLANTS

1. Generally, all transplants must meet the following criteria with no contraindications, and any specific criteria additionally noted:
   (a) The client must have a maximum probability of a successful clinical outcome, i.e., the probability of the client's survival after transplant for a period of five years or more, must be at least 20 percent as supported by medical literature.
   (b) Prior authorization for a transplant will only be given for a client in whom irreversible disease has advanced to the point where conventional therapy offers no prospect for prolonged survival and there is no reasonable alternative medical or surgical therapy.
   (c) A client considered for a solid organ transplant must have a poor prognosis of less than a 50% chance of survival for eighteen months without a transplant as a result of poor functional status.
   (d) Second solid organ transplants must meet all criteria and applicable practice guidelines.
   e) All alternative medically accepted treatments that have a one year survival rate comparable to that of transplantation must have been tried or considered.
   (f) Requests for transplant services for children suffering from early congenital heart disease or early cardiopulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve outcome.
   (g) Both the transplant center and the specialists' evaluations recommend that the transplant be authorized.

2. Donor leukocyte infusions are covered only when:
   (a) an early failure or relapse post allogeneic bone marrow transplant occurs
   (b) peripheral stem cells are from the original allogeneic donor.

3. Allogeneic bone marrow transplants are covered when criteria for antigen match is met.

4. Liver-kidney transplant is covered only for medically-documented diagnosis of Caroli's disease.

5. Simultaneous Pancreas-Kidney (SPK) is covered only for the diagnosis of Type I diabetes mellitus along with endstage renal disease.

6. Pancreas after Kidney (PAK) transplant will be considered for clients diagnosed with insulin dependent Type I diabetes after prior successful renal transplant

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

HEALTH HOMES FOR INDIVIDUALS WITH CHRONIC CONDITIONS
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES: CATEGORICALLY NEEDY

Reserved for future use

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 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 waivered 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 participate in the assessment process.

Oregon's revised Level of Care Assessment (LOC) 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.

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 and signature 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 established tools for nursing facility and ICF/ID LOC, along with additional clinical criteria. 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.

The State will waive the annual Level of Care (LOC) recertification requirement for those who meet established criteria. The criteria define a subset of the eligible individuals and includes profound intellectual disabilities, progressive cognitive disabilities such as Alzheimer's, or a permanent physical disability for whom a medical professional determines that there no possibility of improvement. The State will retain documentation of the reason for waiving the annual recertification requirement for each eligible individual. Every time the person-centered plan coordinator updates the service plan, the individual's care needs will be reviewed to determine if there has been significant improvement indicating that the individual would require a LOC assessment. The update to the service plan will occur no less than annually. For individuals who do not meet the criteria, a LOC determination will be conducted annually.

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 waivered 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 a three step process. The second 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 third step is the person-centered service plan that is individualized to address the individual's strengths, supports, goals and ensures their independence, dignity and well-being.

ii. Service Delivery Models

_X_ 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.

Community First Choice State Plan Option

The State will cover IADL supports including light housekeeping, laundry, 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 (CNS) to support health related tasks within the state's nurse practice act. These services include nurse delegation and care coordination for eligible individuals living in their own home or a Foster Home. 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.

The following list identifies criteria that may lead to a referral for CNS.

- 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.

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. Department contracted Community Nurses will provide these services for individuals living in their own homes or Foster Homes. Payment for CNS will not be allowed when individuals are receiving CFC services in other residential CBC settings. Other CBC residential providers must provide CNS as part of their contracted rate. CNS 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 LTC CNS 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.

Community First Choice State Plan Option

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 (e.g., occupational, physical, communication therapy) or nursing services that must be performed by a licensed therapist or nurse, but may be used to complement therapy or nursing goals when authorized and coordinated through the support 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.

Community nursing services are also in this category of services. Community 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.

Community First Choice State Plan Option

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 $500 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.

Community First Choice State Plan Option

Coverage will be limited to devices and technology not covered by other Medicaid programs (such as the Oregon Health Plan) 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 CBC settings. CBCs 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 plan of care 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, community-based care 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.

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 Behavior 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.

Community First Choice State Plan Option

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 Consultants 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 person-centered plan. Positive Behavior Support Services are prior authorized based on the approved plan of care. Services are provided through behavioral support consultants 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. 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 ability 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.

Community First Choice State Plan Option

Topics will be specific to the individual but include: understanding the Service Plan and Task List, 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, 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:

iv. Information, counseling, training and assistance to ensure that an individual is able to manage the services.

v. Information communicated to the individual in a manner and language understandable by the individual, including needed auxiliary aids and/or translation services.

vi. 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.

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.

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

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 face-to-face depending upon the individual's preference.

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. 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 $500.

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.

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 residential CBC setting. CBC 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 one meal 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 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, Health-Related Tasks and 24-hour availability. 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),

- Instrumental Activities of Daily Living (housekeeping, laundry, medication management, transportation, meal preparation, and shopping), and

- The availability of a live-in provider on a twenty-four hour basis (also known as 24-hour availability).

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. 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, community nursing services, personal emergency response systems, relief care providers, and environmental accessibility adaptations will not be allowed when individuals are receiving CFC services in a residential CBC setting. CBC residential providers must ensure their residents have access to substantially similar services as those living in their own homes.

Health related tasks will be limited to a need or needs, identified through the functional assessment and reflected in the person-centered 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.

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

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.

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

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) _X_ 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.

Community First Choice State Plan Option

(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 will occur prior to functional needs assessment and the development of the service plan. Person-centered plan coordinators conduct a full 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 assessment process and will have the opportunity to identify goals, strengths and needs.

Community First Choice State Plan Option

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. DHS' minimum person-centered plan coordinators 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).

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.

Community First Choice State Plan Option

(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 must meet the priority levels as defined in OAR 411-015-0010 in addition to a clinical criteria score of 100 or higher. 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.

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

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. A significant impairment in adaptive behavior is defined under OAR 411-320-0020(5) (b) as a "composite score of at least two standard deviations below the norm or two or more areas of functioning that are at least two standard deviations below the norm, including but not limited to communication, mobility, self-care, socialization, self-direction, functional academics, or self-sufficiency as indicated in a standard adaptive test."

Person-centered plan coordinators complete the initial LOC assessment and reviews the level of care annually, or more frequently based on the functional needs of the individual, or at the request of the eligible individual. They assessments happen during a face-to-face meeting with the individual. The 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.

Examples include; Vineland, Scales of Independent Behavior – Revised (SIB-R), Adaptive Behavior Assessment Scale (ABAS), and Adaptive Behavior Scale (ABS).

DHS employs a Diagnosis and Evaluation Coordinator (D & E Coordinator), to whom the Services Coordinator sends the initial LOC eligibility determination. The D & E Coordinator makes the final determination from the information provided whether the individual meets the ICF/ID LOC eligibility.

The D & E Coordinator reviews the assessment to ensure:

> That the individual meets eligibility criteria as defined in OAR 411-320-0080 as a person with an intellectual disability or a developmental disability; and a significant need for supports in one or more of the following areas:
>
> Self Direction, Home Living, Community Use, Social, Self Care, Communication, Mobility, and Health & Safety.
>
> A need for supports may include cueing, reminders, redirection, reassurance, set-up, stand-by or hands-on.

Community First Choice State Plan Option

By July 1, 2013, the Department will have a LOC tool clarifying that indicated impairments are explicitly related to eligibility. Additionally, eligibility specialists are expected to 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.

The Hospital LOC assessment is based on an acute care hospital clinical criteria tool that assesses the need for medical interventions based on a point system. The points are determined by the severity, frequency and amount of care or medical oversight needed in the following areas: Urinary & Nephrology (including dialysis), Gastroenterology & Feeding, Metabolic, Neurological, Skin & Physical Management, Respiratory, and Vascular. The tool utilizes age factors in areas where medical interventions might be different for children. Scoring is only allowed for interventions that must be conducted at least once per week and are expected to last for at least six months. Individuals with significant medical needs who score 50 or greater on the acute care hospital clinical criteria will meet the Hospital LOC. A physician and a person-centered plan coordinator must agree that the individual can be safely served in a community based setting.

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.

Community First Choice State Plan Option

(Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual.)
(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.

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 service plan and provide the participant a copy of the service 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.

Community First Choice State Plan Option

The person-centered plan coordinator will consult with service providers and the individual throughout the assessment period 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 Community Nurses, including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. These services are provided to individuals in their own home or foster homes. 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.

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 plan of care.

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.

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

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;

Community First Choice State Plan Option

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 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: ORS 443.422 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 subject to the provisions of ORS 169.690.

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.

Community First Choice State Plan Option

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.

Community First Choice State Plan Option

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.

Community First Choice State Plan Option

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.

Community First Choice State Plan Option

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.

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.

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.

Community First Choice State Plan Option

(1) Initial Certification.

(a) To receive Department certification and be eligible for a Medicaid contract, ADS programs must complete the certification process that includes the following:

(A) An initial certification on-site visit;

(B) Provision of a cover letter detailing qualifications and specific experience in delivering adult day services (at least six months in Oregon);

(C) Completion of an Adult Day Services Medicaid Provider Application;

(D) Completion of the ADS self-assessment demonstrating the program meets the standards for adult day services in OAR 411-066-0020;

(E) Completion of a cost justification for the purpose of establishing a state contracted daily rate; and

(F) Participation in a follow-up on-site inspection by a representative(s) of DHS.

(b) DHS will complete an on-site certification assessment, citing standards as “met” or “unmet”.

(c) If all standards are met, DHS will certify the ADS program.

Adult Foster Care- Licensing requirements at OAR 411-050-0400 - 0491. Branch offices are responsible for verification of provider qualifications upon initial license and annual renewal.

Adult Group Home- Licensing requirements at OAR 411-325-0010 through 411-325-0480. 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. Local offices are responsible for verification of provider qualifications initially and every 12 months.

Community Transition Service Providers- Provider requirements at OAR 461-155-0526 Branch offices are responsible for verification prior to authorizing service and payment.

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, DD or Child

Community First Choice State Plan Option

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 Transportation, Individual provider- Licensing and certification requirements at OAR 309-040-0300 through 309-040-0455; 411-330-0010 through 411-330-0170; 411-360-0010 through 411-360-0310; 411-305-0010 through 411-305-0180. Valid Oregon Driver's License is additionally 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 in the family home or working alone with 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. People providing direct services in the family home or working alone with 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. People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance.

Community First Choice State Plan Option

The family 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.

Community Transportation, Agency Provider- Licensing and certification requirements at OARs 411-325-0010 through 411-325-0480; 411-054-0000 through 411-054-0300; 309-035-0100 through 309- 035-0190; OARs 309-041-0550 through 309-041-0830; 411-345-0010 through 411-345-0300. People providing direct services in the family home or working alone with 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. 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 Adult Foster Care- Licensing requirements at OAR 309-040-0030 through 309-040-0330; 411-050-0040 through 411-050-0490; or 411-360-0010 through 411-360-0310. Local CDDPs and DHS Central Office are responsible for verification of provider qualifications annually.

Developmental Disabilities Support Services Provider Organization- Licensing 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 309-049-0000 through 309-049-0020; 411-325-0010 through 411-325-0480; or 413-210-0000 through 413-210-0883. 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.

Community First Choice State Plan Option

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 and OAR 411-030-0002 - 0090. 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.

In-Home Support Services Provider (Agency)- Certification requirements at OAR 309-041-0550 through 309-041-0830; 411-305-0010 through 411-305-0180; and 411-330-0010 through 411-330-0170; and OAR 309-049-0000 through 309-049-0020. DHS Central Office is responsible for verification of provider qualifications annually.

In-Home Support Provider (Personal Support Worker)- People providing direct services in the family home or working alone with a recipient must pass a Criminal History Check conducted by the state. The CDDP or the family will check the license status of any professional providing services to verify the license is current and unencumbered. 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. People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance. A representative of the CDDP or family will verify that the person can provide the care needed by the individual. The family 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. CDDPs are responsible for verification of provider qualifications prior to provision of services and review annually.

Community First Choice State Plan Option

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
Health Division will license any facility that meets the definition of a residential treatment facility and serves adults with a mental or emotional disorder. In the case of a facility serving another category of residents in addition to adults with mental or emotional disorders, the Department responsible for licensure (OHA or DHS) will be determined by the Directors of those agencies. No person or governmental unit acting individually or jointly with any other person or governmental unit will establish, maintain, manage, or operate a residential treatment facility without a license issued by OHA or DHS. Licenses are renewed biennially.
Skills trainers are hired or monitored by licensed, certified or specialty programs including Adult Foster Care, Adult Group Homes, Assisted Living Facilities, 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 411-323-0030 through 411-323-0030. 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. The CDDP or Supported Living Agency will check the license status of any professional providing services to verify the license is current and unencumbered. 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.

Community First Choice State Plan Option

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 is implementing 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).

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 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.*

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

- **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 enrolled applicants for CFC services.
2. The percentage of CFC participants receiving a redetermination of institutional LOC Numerator: All CFC participants with a LOC redetermination completed prior to 12 months from their initial determination or last redetermination. Denominator: All CFC participants.
3. 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 CFC participants found eligible for services.
4. The percentage of providers identified in a service plan that require licensure and/or certification under Oregon Administrative Rule. Numerator: Providers that prior to providing CFC services initially met and continue to meet qualification requirements. Denominator: All providers providing CFC services.
5. The percentage of providers who are trained per Oregon Administrative Rules and the approved CFC. - Numerator: Providers that are trained per Oregon Administrative Rules and the approved CFC. - Denominator: All Providers.

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

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.
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.
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.
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.
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.
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.
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.
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 participants of this CFC.
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 identified risks and safety considerations.

Community First Choice State Plan Option

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.
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.
17. Percent of individuals who express that they are able to contact appropriate person centered plan coordinators when needed. Numerator: Number of service recipients who express they are able to contact the appropriate PCPC when needed. 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 CFCO to determine their satisfaction and outcomes related to the CFSS 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 CFCO 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.

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

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 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.

Community First Choice State Plan Option

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 service plan 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.

Community First Choice State Plan Option

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.

Alternate Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.
Alternative Benefit Plan Population Name: New Adult group: Program code AMO
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.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Eligibility Group:	Enrollment is mandatory or voluntary
Adult group	Voluntary

Enrollment is available for all individuals in these eligibility group(s). ☒ Yes ☐ No

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.
☒ Yes ☐ No

Any other information the state/territory wishes to provide about the population (optional)

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act ABP2a

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.
☒ 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.

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package
ABP3

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.

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.

Alternative Benefit Plan Cost-Sharing	ABP4

☒ 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.
☐ Yes ☒ No

Other Information Related to Cost Sharing Requirements (optional):

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package.
☐ Yes ☒ No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

PacificSource Preferred CoDeduct Value 3000 35 70

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

**Essential Health Benefits align with OHP Plus. For full descriptions of ABP5 refer to CMS Approval package.

☒ Essential Health Benefit 1: Ambulatory patient service

Benefit Provided:
Physician services

Source:
State Plan 1905(a)

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

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

Benefit Provided:
Nurse Practitioner

Source:
State Plan 1905(a)

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

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

Benefit Provided:
Chiropractor

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Family Planning

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Podiatrist services (OLP)

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Optometrist services (OLP)

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

Benefit Provided:
Tobacco cessation

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

Benefit Provided:
Outpatient hospital

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

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

Benefit Provided:
Hospice

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:	Duration Limit
None	90 day period with subsequent 60-day periods

Scope Limit:

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

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

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

☒ Essential Health Benefit 2: Emergency services

Benefit Provided:	Source:
Outpatient hospital services	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

Benefit Provided:	Source:
Emergency-Physician services	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

Benefit Provided:	Source:
Emergency-medical transportation-outpt hsp	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

☒ Essential Health Benefit 3: Hospitalization

Benefit Provided:	Source:
Inpatient hospital	State Plan 1905(a)
Authorization :	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:	Source:
Physician-inpatient hospital	State Plan 1905(a)
Authorization :	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

Benefit Provided:
Maternity care-Physician services

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Maternity care-Nurse practitioner

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Maternity care-Nurse Midwife

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:	Source:
Inpatient hospital-MH/SUD	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:	Source:
Outpatient hospital-MH/SUD	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:
Physician services -MH/SUD

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Nurse practitioner -MH/SUD

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

☒ Essential Health Benefit 6: Prescription drugs

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

Prescription Drug Limits (Check all that apply.):
- ☒ Limit on days supply
- ☐ Limit on number of prescriptions
- ☐ Limit on brand drugs
- ☐ Other coverage limits
- ☒ Preferred drug list

Authorization:
☒Yes

Provider Qualifications:
State Licensed

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.

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

Benefit Provided:
Inpatient hospital- Rehabilitative

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Outpatient hospital- Rehabilitative

Source:
State Plan 1905(a)

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Benefit Provided:
Physical,speech & occupational therapy- Reh/Hab

Source:
State Plan 1905(a)

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services and limits per plan of care, some services require authorization, limits can be exceeded when medically necessary

Benefit Provided:	Source:
Home health- Reh/Hab	State Plan 1905(a)
Authorization :	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:	Source:
Prosthetic devices- Rehab/Hab	State Plan 1905(a)
Authorization :	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:	Source:
Eyeglasses	State Plan 1905(a)
Authorization :	Provider Qualifications:
Prior Authorization	Medicaid State Plan

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

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

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

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

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

Benefit Provided:
Dentures

Source:
State Plan 1905(a)

Authorization :
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits for age 21 and over

Duration Limit
Limits for age 21 and over

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

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

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

Benefit Provided:	Source:
Nursing Facility Services-Skilled	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
Level of care needs	Level of care needs

Scope Limit:

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

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

Screening and assesment to determine level of care needs.

☒ Essential Health Benefit 8: Laboratory services

Benefit Provided:	Source:
Laboratory & X-ray	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

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

Benefit Provided:	Source:
Preventive services	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

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

Benefit Provided:	Source:
Medicaid State Plan EPSDT Benefits	State Plan 1905(a)
Authorization :	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	Duration Limit
None	None

Scope Limit:

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

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

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication

Base Benchmark Benefit that was Substituted: Source:
Primary care to treat illness/injury 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: Source:
Specialist visits 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: Source:
Outpatient 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:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) 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:	Source:
Radiation therapy	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:	Source:
Sterilization	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

Base Benchmark Benefit that was Substituted:	Source:
Home health care	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:	Source:
Telemedical services	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:	Source:
Care for disease of the eye	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.

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

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

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

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

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

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

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

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

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice / respite care services were bundled, along with primary care to treat illness/injury, specialist visits and mapped to the ‘‘Ambulatory patient services’ EHB category. The bundled services are a duplication of hospice services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Pre- & postnatal care services were bundled, along with Maternity services and mapped to the 'maternity and newborn care' EHB category. The bundled services are a duplication of maternity care-physician, maternity care-nurse practitioner, maternity care-nurse midwife services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & inpatient maternity services were bundled, along with Maternity services and mapped to the 'hospitalization' EHB category. The bundled services are a duplication of inpatient hospital services from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

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

Base Benchmark Benefit that was Substituted:	Source:
Prosthetics	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:

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

Base Benchmark Benefit that was Substituted:	Source:
Orthotics	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:

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

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

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

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

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

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Lab tests, x-ray services, & pathology were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

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

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

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

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

Genetic testing services were bundled, and mapped to the 'Laboratory services' EHB category. The bundled services are a duplication of Laboratory and X-ray section from the existing state Medicaid plan.

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

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

Base Benchmark Benefit that was Substituted:	Source:
Smoking cessation program	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 cessation program were bundled, and mapped to the 'Ambulatory patient services' EHB category. The bundled services are a duplication of tobacco cessation sections from the existing state Medicaid plan.

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

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

Base Benchmark Benefit that was Substituted:	Source:
Dentures	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:

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

Base Benchmark Benefit that was Substituted:	Source:
Skilled nursing	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:

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

Base Benchmark Benefit that was Substituted:	Source:
Outpatient hospital	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 hospital - facility services were bundled, and mapped to the 'Outpatient hospital' EHB category. The bundled services are a duplication of Hospital - Outpatient services from the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Organ & tissue transplants

Source: Base Benchmark

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

Base Benchmark Benefit that was Substituted: Newborn child coverage

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:

Newborn services are billed separately through the newborn's Medicaid ID

☒ Other 1937 Covered Benefits that are not Essential Health Benefits

Other 1937 Benefit Provided: Dental

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization : Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Limits for age 21 and older

Duration Limit: None

Scope Limit:

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

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

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

Other 1937 Benefit Provided:
Clinic services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Other 1937 Benefit Provided:
Targeted Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Other 1937 Benefit Provided:
Non emergency medical transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

Other:

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

Other 1937 Benefit Provided:
Private duty nursing services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

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

Other:

Level of care assessment.

Other 1937 Benefit Provided:
Extended services for pregnant women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

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

Other 1937 Benefit Provided:
Personal Care services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

Other:
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.

Other 1937 Benefit Provided:
Nursing Facility Services-Long Term

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Level of care need

Duration Limit
Level of care need

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

Other:
Screening and assessment to determine level of care needs.

Other 1937 Benefit Provided:
PACE

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

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

Other:
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.

Other 1937 Benefit Provided:
Health Home for individuals with chronic condition Package

Source:
Section 1937 Coverage Option Benchmark Benefit

Authorization :
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit
None

Scope Limit:

Services provided within the scope of practice as defined under state law and recognized by the Oregon Health Authority as a PCPCH.

Other:

Although the PCPCH model for all OHP populations is part of Oregon's transition in healthcare, the separate reimbursement for PCPCH model for chronic conditions under Section 1945 of the Social Security Act is effective only from January 1, 2014 through June 30, 2014.

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.

Benefit Assurances	ABP7

Prescription Drug Coverage Assurances (Cont)

☒ 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.

☒ 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.

☒ 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

☒ 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.

☒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.

Benefits Assurances	ABP7

☒ 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.

☒ 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.

☒ 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.

☒ 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.

☒ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☒ 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 reventive services for women recommended by the Institute of Medicine (IOM).

Service Delivery Systems	ABP8

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.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s):

☒ Managed care.
- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☒ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.
☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☒ 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.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

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 eligbles 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.

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: July 5, 2012
Describe program below:

Oregon transitioned from using Fully Capitated Health Plans to Coordinated Care Organizations in 2013. As authorized under an 1115 waiver demonstration Oregon's delivery system has transitioned from using Managed Care Entities(MCE) known as Fully Capitated Health Plans, Dental Care Organizations and Mental Health Organizations to Coordinated Care Organizations beginning in August 2012. Initially, CCOs were required to provide both medical and behavioral health services (formerly provided under different MCEs). CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. CCOs are located throughout the state. OHA also 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.

Additional Information: MCO (Optional)
Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan
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 1115 demonstration
☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: July 5, 2012

Describe program below:

As described above, under 1115 waiver authority Oregon is transitioning from using Dental Care Organizations to Coordinated Care Organizations by 2014. Some DCO's has already contracted with the CCO's however, some are still stand alone DCO's/PAHPs. DCO's are located throughout the state and provided dental services to those enrolled with the DCO or with the contracted CCO. The CCOs are located throughout the state and coordinate all health related services for their enrollees, including physical, mental, dental and substance abuse services.

Additional Information: PAHP (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

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 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). OHA also 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 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).

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Employer Sponsored Insurance and Payment of Premiums	ABP9

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.

☒ Yes ☐ No

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:

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."

The state/territory otherwise provides for payment of premiums.
Other Information Regarding Employer Sponsored Insurance or Payment of premiums:

General Assurances	ABP10

Economy and Efficiency of Plans

☒ 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.
☒ Yes ☐ No

Compliance with the Law

☒ 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.
☒ 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).
☒ 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

☒ 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:
☐ Yes ☒ No

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.

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:

   - **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.

   - **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

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.

0 **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 XlX 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.

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 categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount of Basis for Determination
Prescribed Drugs			X	$1 for each Non-Preferred PDL generic or Generics costing .$10. $0 Preferred PDL Generics $0 Preferred PDL Brands $3 All other Brands
Acupuncturist			X	$3 per visit
Physician Services			X	$3 per visit
Alcohol and Drug			X	$3 per visit, excludes dosing/dispensing or case management visits
Audiologist			X	$3 per visit
Chiropractor			X	$3 per visit
Dental Services			X	$3 per visit, excludes diagnostic or routine cleaning
Home Health			X	$3 per visit
Hospital outpatient			X	$3 per visit
Ambulatory Surgical			X	$3 per visit
Mental health			X	$3 per visit
Naturopath			X	$3 per visit
Nurse practitioner			X	$3 per visit
Occupational Therapy			X	$3 per visit
Optometrist			X	$3 per visit
Physical Therapy			X	$3 per visit
Speech therapy			X	$3 per visit
Podiatrist			X	$3 per visit

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

B. The method used to collect cost sharing charges for categorically needy individuals:

X Providers are responsible for collecting the cost sharing charges from individuals.

_____ The agency reimburses providers the full Medicaid rate for services and collects the cost.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Medicaid recipients who indicate to the provider that they cannot pay the co-payment at the time the service is provided cannot be refused services because of their inability to pay. However, recipients are liable for the copayment and are expected to pay the co-payment when they are able to do.

Providers are informed that they cannot refuse services to a Medicaid recipient solely because of the recipient's inability to pay the co-payment. The provider can use any other legal means to collect.

The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below.

Adjustments to provider reimbursement amounts and exclusions from cost sharing requirements are programmed into the Point-of sale System (POS)

Individuals under 19: The MMIS and POS system automatically verifies benefits and age requirements and will override the co-payment for recipients under 19. Additionally the medical ID card shows the recipients date of birth should the provider wish to verify age prior to collection of co-payment.

Pregnant Women: The MMIS and POS reporting codes will identify and exclude pregnant woman from cost share. If the case has not been previously identified and coded the provider is instructed to contact provider services for an override of the co-payment.

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

State/Territory: OREGON

Institutionalized Individuals: The MMIS and POS reporting codes will identify and exclude residence to nursing facilities or other institutionalized residence from cost share. If the case has not been previously identified and coded the provider is instructed to contact provider services for an override of the co-payment. Providers have been instructed not to collect cost sharing from these institutionalized individuals. Facilities have been instructed to assure that staff accompanying recipients out of the facility for health care visits advises providers of the recipient's institutional status.

Emergency Services: The providers have been instructed not to collect cost sharing amounts from individuals seeking or obtaining emergency services. The provider identifies that the service provided was an emergency by entering a code in the appropriate field on the POS system.

Family Planning Services, Drugs and supplies: The MMIS & POS System will identify and exclude family planning services, drugs such as birth control pills, and supplies from cost share.

IHS/Tribal Health Facilities under Section 638: To identify Indians exempt from cost sharing, the State obtains a letter or other IHS document verifying current or previous use of services provided by the IHS or an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) in any State, which serves to exempt the Indian from all cost sharing.

Mail Order Prescription: The POS system will identify and exclude prescription drugs dispensed through the mail order drug program.

Tobacco Cessation: Nicotine Replacement Therapy is exempt from co-payments.

E. Cumulative maximums on charges:

X State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:

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 Deduct. Coins. Copay.	Amount of Basis for Determination

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.

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.

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.

STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT

STATE OF 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.

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:

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.

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 GROUPER

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-weighing 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.

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

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:

	Billed charges less non-covered charges
X	Hospital-specific cost-to-charge ratio
=	Net Costs
-	270% of the DRG or $25,000 (whichever is greater)
=	Outlier Costs
X	Cost Outlier Percentage
=	Cost outlier Payment

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:

Total relative weights from claims paid during the quarter
X Indirect Medical Education Factor
= Indirect Medical Education Payment

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.

P&I

(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:

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 I 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.

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 impatient 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Oregon
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

- 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 subsides 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 hospitals 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 hospitals 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 attributive 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The State has in place a public process which complies with the requirements of Section 1902(a)(l3)(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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 1/1/13 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/healthplan/data_pubs/feeschedule/main.shtml

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 services, Physician Assistant 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. Fees for drugs administered in the provider's office is based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate shall be based upon *the Wholesale Acquisition Price (WAC) plus 6.25%. 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.
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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Provider type/ Service type	Payment method
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 1/1/15.
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 upon75% 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.
8. Private Duty Nursing Services:	Payment for services is a state-wide fee schedule based on community wages set in 1993 with periodic CPI increases.
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.
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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Provider type/ Service type	Payment method
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	Emergency Transport- Payment for emergency medical transportation services is a state-wide fee schedule. The rate is posted on the agency web at: http://www.oregon.gov/oha/healthplan/pages/data_pubs/feeschedule/main.aspx Non-emergency transports not provided/arranged by the brokerage system as authorized under 1115 waiver authority- NEMT ambulance level transports is a state-wide fee schedule. Client and necessary attendant reimbursement- mileage is $0.25 per mile and is all-inclusive. Meals- Breakfast: $3.00,Lunch: $3.50,Dinner: $5.50 Lodging- the lesser of the actual cost, or $40 per night. Volunteer drivers-Rides are reimbursed per standard GSA mileage rates for business miles driven.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Provider type/ Service type	Payment method
24.f. Personal Care Services (cont)	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 settings, AMH has developed a base number of hours of personal care per facility type per day, which when multiplied by the hourly rate specific to that facility type, provides the base rates. The base hours of personal care need are Adult Foster Home (3); Residential Treatment Home/Facility (4); Secured Residential Treatment Facility (6). Providers who document service needs in excess of the base personal care needs are eligible to receive enhancements up to 6 hours of additional need per day. The personal care service rates provided in these residential settings do not include reimbursement for room and board. 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: http://www.oregon.gov/oha/amh/mho/codes/amh-rates2013-01.pdf

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Provider type/ Service type	Payment method
24.f. Personal Care Services	For Children in a Foster Care Setting: 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. There are four levels of care: Level 1 - $47.77 per week; Level 2 - $95.30 per week; Level 3 - $143.07 per week; and Level 4 - In extraordinary situations where continuous observation and/or interventions may be required, individualized rates are developed based on the child's needs.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 8/1/2011. The fee schedule is posted on the agency web at: http://www.oregon.gov/OHA/amh/tools-providers.shtml. 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.

The provider types, as outlined in section 13.d, pages 6-d.6 to 6-d.9, can bill, depending on the services provided, in 15 minute units, daily or monthly frequency, accordingly to the CPT/HCPCS billing code utilized.

Interpretive services are billed by the mental health providers and reimbursed an add-on payment as part of the delivery of a Medicaid service. Providers authorized must be qualified interpreters and not immediate family members. Interpretive services (T1013) are included in the fee scheduled referenced above.

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 8/1/2011. The fee schedule is posted on the agency web at: http://www.oregon.gov/OHA/amh/tools-providers.shtml.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.

Interpretive services are provided as an optional medical service under the rehabilitative SUD Services. Interpretive services are billed by the SUD Services providers and reimbursed an add-on payment as part of the delivery of a Medicaid service. Providers authorized must be qualified interpreters and not immediate family members. Interpretive services (T1013) are included in the fee scheduled referenced above.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

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.

Rehabilitative School-Based Health Services

Special Rehabilitation Services Provided by Local Education Agencies

Payment will be based on a local education agency's (LEA) most recent school year's actual audited costs for total amount (federal share plus state share). LEAs shall be surveyed annually using cost worksheets approved by the Department. The cost worksheets shall establish a LEA's hourly and 15-minute increment costs for each discipline. Based upon the data received in the annual cost worksheets, the Department shall establish the maximum allowable hourly cost for each discipline and the maximum allowable cost for each visit code. The LEA shall use the annual indirect rate established for the LEA's district by the cognizant federal agency delegate, the Oregon Department of Education. A LEA shall not bill for more than its annually established cost amount. There will be no required annual cost settlement for each LEA.

LEA-specific costs for its provider disciplines, other than those for non-emergency transportation, shall be determined for each discipline, using the following table:

	Costs Attributable to Discipline	(A) Costs	(B) Percentage	(C) Adjusted
1	Total salaries and benefits for all licensed billable staff			
2	Employee travel expenses			
3	Communications			
4	Publications and printing			
5	Materials and supplies			
6	Professional service costs			
7	Memberships and subscriptions			
8	Repair of equipment used by discipline			
9	Training			
10	Advertising for personnel			
11	Management, salaries, benefits, costs			
12	Medicaid Operations salaries, benefits, costs			

13	Clerical staff salaries, benefits, costs			
	Calculation of Hourly Cost			
14	Number of licensed billable staff in unit (FTE)			
15	Average cost based on FTE			
16	Rate per hour using actual number of total hours worked per year			
17	ODE approved indirect rate			
18	Calculated hourly rate			
19	15-minute increment			

Instructions for Completing Section on Costs Attributable to Discipline

This section shall be completed using actual audited costs from the prior school year for the specified cost classifications. Actual costs shall be listed under Column A. In Column B, the percentage of the total cost listed in Column A that applies to the discipline shall be specified. Column C amount for each cost shall be the result of multiplying Column A by Column B.

Instructions for Completing Section on Calculation of Hourly Cost

This section shall be completed by entering the number of licensed billable staff in the discipline, and the total number of hours worked by all members of the discipline during the prior school year. An indirect rate approved by the Oregon Department of Education may be entered provided the costs included in the indirect rate calculation are not included elsewhere in the calculation of the hourly rate.

Payments for IEP/IFSP Transportation Services Provided by a Local Education Agency

Transportation services are provided to IDEA and Medicaid eligible children with medically necessary transportation services included on their IEP/IFSP.

By computing the total IDEA special education transportation costs, (including costs attributed to individual transportation aides), and following the formula described below to establish Medicaid transportation costs, a per trip rate is the result. The per trip rate is established using the most recent school year's audited actual costs and special education data.

Payments for IEP/IFSP Transportation Services Provided by a Local Education Agency (cont'd)

Medicaid Transportation per trip calculation	Example*
1. Total annual direct costs of all special education transportation costs	$100.00
2. Percent of Medicaid special education students	40%
3. Medicaid transportation costs	$40.00
4. Total number of actual trips per Medicaid student per year	208
5. Direct Medicaid cost per trip	$.19
6. Department of Education indirect rate	12%
7. Total Medicaid cost per trip	$.21

*The numbers used are for example purposes only and not to be recognized as an actual rate.

The following is the description of the example above. Costs will be derived from the most recent school fiscal years' audited costs. All other numbers will be actual service numbers from the same fiscal year.

1. Total IDEA special education direct transportation costs are computed following OMB Circular A-87 guidelines for allowable costs. Included in these costs will be the allowable costs attributed to the individual transportation aide when medically necessary on a regular education bus. The time of the individual transportation aide will not be included nor billed separately. This computation will not include delegated health care aides. Costs used are direct costs, and are not used in developing an indirect cost rate.

2. Established by actual data, this is the percent of special education students requiring medically necessary transportation who are Medicaid recipients. Calculation is: Divide

Payments for IEP/IFSP Transportation Services Provided by a Local Education Agency (cont'd)

the total number of Medicaid recipient students requiring transportation by the total number of special education students requiring transportation.

3. The total annual amount of direct Medicaid transportation for the LEA. Calculation is: Multiply line 1 by percent found in line 2.

4. Total number of actual trips provided to Medicaid recipients by the LEA, derived from transportation logs. Calculation is: Total number of IDEA/Medicaid recipients multiplied by the total number of trips per year provided to these Medicaid recipients; includes all trips covered (billed) and not covered (not billable) trips.

5. Direct Medicaid cost per trip cost. Calculation is: Divide line 3 by line 4 = $.19.

6. Oregon Department of Education (ODE) indirect rate (standard methodology used by LEA's statewide and regulated by ODE). Calculation is: Line 5 multiplied by line 6 (example is 12%)

7. Total Medicaid cost per trip = $.21. Calculation is: Add line 5 and result of line 6 calculation.

The calculation methodology would be the same for LEA owned transportation or LEA contracted transportation. For contract transportation, the contract amount would be line 1.

LEA would bill per trip cost for Medicaid recipient students only on those days when medically necessary transportation is provided and a Medicaid-covered service pursuant to their IEP/IFSP is provided. For example, a child may be transported 10 trips per week, yet the LEA may only bill transportation for 6 trips per week when the child receives a Medicaid covered service as specified on his/her IEP/IFSP. All transportation and service documentation will remain as required. The LEA will not bill the transportation aide separately.

For LEA's billing transportation for the first time, the most recent fiscal years' actual audited costs would still be used for line 1 as instructed, and prospective data would be used to complete the formula.

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

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs

A. General

(1) The Division of Medical Assistance will pay the lesser of the provider's usual charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee. The EAC is defined by the Division as the lesser of:

a. The Average Acquisition Cost (AAC) of the drug. The AAC will be established by the Division 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 AAC is available, reimbursement will be Wholesale Acquisition Cost (WAC). WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter;
c. The Division determines usual charge to be the lesser of the following unless prohibited from billing by federal statute or regulation:

i. The provider's charge per unit of service for the majority of non-Medical Assistance users of the same service based on the preceding month's charges;
ii. The provider's lowest charge per unit of service on the same date that is advertised quoted or posted. The lesser of these applies regardless of the payment source or means of payment;
iii. Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources are to be considered.

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

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

(2) The Division requires prior authorization of payment for selected therapeutic classes of drugs. These drug classes are listed in the Oregon Administrative Rules, Pharmaceutical Services Program. Exception to the prior authorization requirement may be made in medical emergencies.
(3) The Division will reimburse providers only for drugs supplied from pharmaceutical manufacturers or labelers who have signed an agreement with CMS or who have a CMS approved agreement to provide drug price rebates to the Oregon Medicaid program.
(4) The Division utilizes a contracted mail order vendor, the program is voluntary for the enrollees. The vendor is selected via a standard invitation to bid process. All Medicaid program rules apply to the vendor contract, payment rates are established during the bid process.

B. Payment Limits for Multiple Source Drugs

(1) Reimbursement for multiple source drugs in the Medicaid Program shall not exceed the lowest of:
a. The federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS plus a dispensing fee;
b. The Estimated Acquisition Cost (EAC) defined by the Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) plus a dispensing fee ; or
c. The provider's Usual and Customary charge to the general public for the drug.

(2) Payment for multiple-source drugs for which CMS has established upper limits will not exceed, in the aggregate, the set upper limits plus a dispensing fee.

(3) Oregon state law requires that no payment shall be made for a multiple source drug having a federal upper limit (FUL) for payment if a less expensive multiple source drug could have been dispensed, unless the physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient.

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

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

C. Payment Limits for Single-Source Drugs

(1) The Division established the payment amount for single-source drugs shall not exceed the lowest of:
   a. The Estimated Acquisition Cost (EAC) defined by the Medicaid as the Average Acquisition Cost (AAC) of the drug; or
   b. In cases where no AAC is available, Wholesale Acquisition Cost (WAC) plus a dispening fee; or
   c. The provider's Usual and Customary charge to the general public for the drug.

(2) The upper payment limit established by the State EAC listing does not apply if a prescriber certifies that an innovator multi-source drug is medically necessary.
(3) Payments for single-source drugs shall not exceed, in the aggregate, the lesser of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual charge to the general public.

D. Payment limit for 340B entity

(1) The Division established the payment amount for 340B entities shall not exceed the entity's actual acquisition cost plus a dispensing fee.

E. Dispensing or Professional Fees

(1) The Division establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies. The dispensing fee structure will be one of 3 rate tiers. The Division or its designated representative will conduct an annual survey of every enrolled pharmacy to determine which tier the pharmacy will be paid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

(2) Based upon the annual volume of the enrolled pharmacy, the dispensing fee will be as follows:

- Less than 30,000 claims a year = $14.01
- Between 30,000 and 49,999 claims per year = $10.14
- 50,000 or more claims per year = $9.68

(3) Pharmacies that fail to respond to the annual survey will default to the $9.68 dispensing fee.

(4) Pharmacies dispensing through a unit dose or 30-day card system must bill the Division only one dispensing fee per medication dispensed in a 30-day period.

(5) Dispensing fee tiers are applicable to all pharmacies: retail independent, Institutional, mail order, compounding and 340 programs. Retail chain affiliated pharmacy dispensing fee is paid at the lowest tier regardless of volume.

(6) Independently owned pharmacies in communities that are the only enrolled pharmacy within a fifteen (15) mile radius from another pharmacy shall be reimbursed at a dispensing fee of $14.01.

Payment Methodology for Targeted Case Management for Child Welfare and Oregon Youth Authority

Targeted case management services will be billed at a monthly rate which is based on one or more documented targeted case management services provided to each client during that month. The rate will be based on the cost of providing the monthly 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.

The monthly rate for targeted case management services is based on the total average cost per client served by the provider. The cost used to derive the monthly rate will be limited to the provider's direct service and administrative costs associated with targeted case management service delivery.

The monthly rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients to be served. For subsequent years, the rate will be based on actual targeted case management costs for previous year, adjusted for anticipated changes in the actual costs and number of clients to be served for the coming year. A cost statement will be completed at the end of each state fiscal year once the actual costs incurred have been determined.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(Reserved for future use)

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(Reserved for future use)

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.

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

State/Territory: OREGON

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.

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

State/Territory: OREGON

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

Payment Methodology for Targeted Case Management for persons with Tuberculosis

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 Tuberculosis Targeted Case Management services and the fee schedule and any annual/periodic adjustments to the fee schedule.

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 Tuberculosis 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.

Payment Methodology for Targeted Case Management for Substance Abusing Parents with young Children

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. Fee schedule was last updated 1/1/09 and are effective for services on or after that date.

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

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

State/Territory: OREGON

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.

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

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Methodology for Targeted Case Management for Medicaid High Risk Infants and Children

"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:

Compute the	Total Annual Medicaid Encounters
Compute the	Total Annual Program Expenditures
Divide	Calculate Average Cost Per Encounter
Examine	Extreme values, develop "reasonable range"
Equals	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 9/2/2012 and are effective for services on or after that date. All rates are published on the Agency's website at http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/main.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ____Oregon_____

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ____Oregon_____

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.

Payment Methodology for Targeted Case Management

Rate Determination: The monthly rate for case management services for parents is based on the total average monthly cost per client served by the provider. The monthly rate will be limited to the provider's direct service and administrative costs associated with case management service delivery.

The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients to be served. For subsequent years, the rate will be based on actual case management costs for previous years. A cost statement will be completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. The client is considered to have been provided some case management services if there has been an encounter between a case manager and the client during that month. Each encounter will be documented to support the billing.

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

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%.

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

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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.

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

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.

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

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ___OREGON_____

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: ____OREGON_____
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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.

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 injectible drugs.

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. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Fee for Service Reimbursement Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services. The existing reimbursement rate for the codes will be adopted. S5136HK-HW (monthly rate) for individuals living in independent settings, S5141HK-HW (monthly rate) for Adult Foster Homes, S5140HK-HW (daily) for Residential Treatment Homes, and T2048HK-HW (daily) for Residential Treatment Facilities. AMH 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. The rates for individuals living in independent settings, Adult Foster Homes, Residential Treatment Homes and Residential Treatment Facilities were last updated 01/01/2012 and are applicable to services rendered on or after that date. The Rate Schedule is posted at: http://www.oregon.gov/OHA/mentalhealth/tools-providers.shtml#codes
☐	HCBS Respite Care

§1915(i) HCBS State plan Services
State/Territory: Oregon

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☑	HCBS Psychosocial Rehabilitation
		Fee for Service Reimbursement Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services. The existing reimbursement rate for the codes will be adopted. AMH will periodically audit the providers that receive daily reimbursements 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. The rates for Psychosocial Rehabilitation were last updated 01/01/2012 and are applicable to services rendered on or after that date. The Rate Schedule is posted at http://www.oregon.gov/OHA/mentalhealth/tools-providers.shtml#codes.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

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.

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:

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Methodology for Health Homes for Individuals with chronic Conditions

Payment Type: Per Member Per Month

Provider Type

These include physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine, Certified Nurse Practitioners and Physician Assistants), clinical practices or clinical group practices, Federally Qualified Health Centers, Rural Health Clinics, Tribal clinics, Community health centers, Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers.

Description

PCPCH/Health Home receive am amount per member per month based upon the standard met by the individual practice or provider group. The PCPCH/Health Home measures are divided into "Must-Pass Measures" and levels or "Tiers" that reflect basic to more advanced PCPCH/Health Home functions. Must-Pass and Tier 1 measures focus on foundational primary care home elements that should be achievable by most primary care clinics in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advanced functions.

Tier 1, $10 PMPM
Tier 2, $15 PMPM
Tier 3, $24 PMPM

The PMPM management fee will be made monthly, is in addition to the FFS payments made for direct services under state plan authority for those provider types listed above. In order to be considered an authorized payment, PCPCH/Health Home services and related activities are documented in the patients' medical record at a minimum, each quarter, for ACA qualifying members. The payment is made on a monthly basis to recognized PCPCH providers, but unit of service is quarterly. Providers must render and document a core service, or activity consistent with the definition of a core service, at a frequency not less than quarterly. In order to document the provision of a core service, PCPCH providers, or a managed care plan on behalf of and working with a PCPCH provider, will submit a beneficiary roster of PCPCH/Health Home eligible beneficiaries under their assigned care within the quarter.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The Oregon Health Authority will only make payment for ACA qualified beneficiaries that are reported no less than quarterly. Provision of a core service will be documented by a PCPCH provider in each beneficiaries' medical record. In order to supplement documentation of the provision of a core service and/or activity, PCPH providers will also log into a provider portal/panel management system currently maintained by the Quality Corporation, a subcontractor of the OHA, or an alternative system approved by the OHA. In order to use an alternative provider portal/panel management system, providers would need to demonstrate to the OHA that the proposed system has similar capability as the Quality Corporation system. Providers will review data regarding the services rendered to Medicaid beneficiaries, allowing the provider to more effectively manage and identify gaps in services provided to their patient panels. The log generated from the provider portal and/or the list of approved alternative provider portals will be reconciled to the PCPCH provider roster on a quarterly basis to ensure that these providers are conducting "comprehensive care management," one of the core services. In the event that an activity is not documented within the quarter, FFP will be returned to CMS. Provider (s) receiving payments are subject to audit or other post payment review procedures for any payments applicable to items or services furnished or supplied by the provider to Medicaid clients. The lack of required documentation will be considered an overpayment and subject to recoupment consistent with Oregon's audit and recovery procedures.

Prior to the implementation of PCPCH/health homes, Oregon's Medicaid managed care organizations provided considerable care management functions on behalf of their members. With the implementation of Patient Centered Primary Care Homes, care management is provided through the PCPCH. Medicaid managed care organizations are required to assist providers within their delivery system to establish PCPCH's and expand the availability of PCPCH's to their members. In addition managed care organizations are required to promote and assist other providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Managed care organizations are required to provide reports to DMAP on the the number of PCPCH recognized provders in their network, number of members assigned to PCPCH, and number of members meeting CMS approved SPA criteria for ACA sec. 2703 who are assigned to a PCPCH.

The fee schedule is the same for both governmental and private providers. Payment for case management or targeted case management services under the plan does not duplicate payments with Home and Community Based Services.

Page 18-26
Reserved for future use

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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, 2013**. All rates are published at: http://www.oregon.gov/dhs/spd/pages/provtools/index.aspx

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.

Community First Choice State Plan Option

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

Community First Choice State Plan Option

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- The FC Support Needs Assessment Profile (SNAP) 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 SNAP 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 Adult Foster Care- The FC Support Needs Assessment Profile (SNAP) 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 SNAP 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.

Community First Choice State Plan Option
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.

Group Care Homes for Adults- Each individual's support needs be assessed using the Supports Intensity Scale (SIS) developed by the American Association for Intellectual and Developmental Disabilities (AAIDD). DHS Assessment Specialists conduct the SIS for each individual upon program entry and when a change in an individual's support needs is identified. 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 SIS assessment collects information about the person's support needs in seven domains, as well as any exceptional medical and behavioral 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 SIS-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.

Group Care Homes for Children- Group home rates are set based on children's individual needs within the group home setting. The rate setting budget tool is completed on a DHS mandated format, using DHS established rates. The rate setting budget tool takes into account the broad range of children's needs, including staffing level, behavior consultation, specialized interventions tailored to the child's disability, and 1:1 staffing. 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. The process is facilitated through the DHS Residential Specialist coordinating the child's care. These exceptional need rates are reviewed quarterly by the DHS Residential Specialist and Residential Manager for continuing need. Proposed staffing, management oversight, and consultation are entered into the budget tool along with projected expenses for program services and supplies, and transportation.

Community First Choice State Plan Option

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 three 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

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.

Community Registered Nurses- Community 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 Community RN will request prior-authorization and submit claims for client services utilizing billing codes per instructions in the Community 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 Agency Providers- The SL budget tool is individualized and based on what level of staff and agency supports are required to meet specific individual service needs. The SL budget tool also is completed on DHS mandated formats, and uses 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 Plan of Care, that require additional levels of skill on the part of the provider, or additional staffing to meet the individual's needs.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

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 require multiple providers that must 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.

Exceptional payments for services received by in-home providers are made for the provision of in-home services, documented in the Plan of Care, that exceed the maximum number of hours of service under rule. All exceptional rate payments are pre-approved centrally by a committee consisting of DHS Program and Rate setting staff and management. 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 plan of care 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.

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*(Portland GPCI) + 33* (Rest of State GPCI))/36 = 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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

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

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

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

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 an Page 3 in item ___ of this attachment (see 3. above).

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

QMBs:	Part A SP	Deductibles SP	Coinsurance
	Part B SP	Deductibles SP	Coinsurance
Other Medicaid Recipients	Part A SP	Deductibles SP	Coinsurance
	Part B SP	Deductibles SP	Coinsurance
Dual Eligible (QMB Plus)	Part A SP	Deductibles SP	Coinsurance
	Part B SP	Deductibles SP	Coinsurance

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.

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1. (Reserved for future use)

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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.

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.

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

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 pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit; and

E. 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.

F. 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 medication**)**;

(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

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(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;

(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.

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. 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.

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. 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;

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(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.

(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 or 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.

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

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 and Complex Medical Needs Add-on 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 and Complex Medical Needs Add-on Rate.

1. Basic Rate and Complex Medical Needs Add-on 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 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, if any.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For each facility, its allowable costs, less the costs of its self-contained pediatric unit (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 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.

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, 2020, 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.

(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.

* DRI compiled from *the IHA Economics, Healthcare Cost Review* Report, Table 6.7 titled "CMS Nursing Home without Capital Market Basket

(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.

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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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.

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.

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.

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:

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	$104.98
Adjusted Model Budget Rate	$ 99.50
Lower Amount is New Interim Rate	$ 99.50

(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

Category			Original Model Budget	Adjustments	Adjusted Model Budget
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		$0.00	$0.00	$0.00

INTERIM RATE
FOR JULY 1,

EXAMPLE ONLY

1. Period	Days in Period	X	Licensed Beds	=	Capacity Days
7-1-90 thru 6-30-91	365		0		0

2. Residents by Classification (By Cottage)	Resident Days	/	Days in Period	=	Average Residents by Classification
A.	0		365		0.00
B.	0		365		0.00
C.			365		0.00
Total	0		365		0.00

3. Physical Therapy Classification	Hours Per Day per Resident	X	Average Residents Per Day	=	Resident Hours Per Day
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

Classification	Average Res. Days	/=	Shift	/=	Shift	/=	Shift	Total
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.

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	$95.32
Capacity Days	3,650
Ceiling Dollars	$347,918.00
Actual Resident Days	3,554
Ceiling Rate	$97.89
Total Expenditures Per Cost Statement	$341,072.00
Less: Adjustments	.00
Net Allowable ICF/MR Expenditures	$341,072.00
Actual Resident Days	3,554
Actual Net Per Diem Cost	$95.97
Settlement Rate (Lesser of Ceiling or Actual Net Per Diem Cost)	$95.97

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	Settlement Rate	Interim Rate	Settlement rate minus Interim Rate	Resident Days	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.

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 PROGRANIS

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.

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. 32l2, 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.

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
Relig4ous 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

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.

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	CLASSIFICATION UNDER WHICH RATES WERE CHARGED* #1	#2	#3	#4	#5	#6

*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.

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			

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
	Current Administrator

RELATED ORGANIZATIONS*
(*Defined in Rule 461-17-600 of the ICF/MR-Provider Guide)

NAME	DESCRIPTION OF SERVICES, FACILITIES, AND SUPPLIES	NATURE OF RELATIONSHIP

Cost of goods or services to the related organization and charge to the facility shall be listed by account on Schedule A.

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

REVENUE

ACCOUNT #	ACCOUNT	(1) + FACILITY GROSS REVENUE	(2) + HOME OFFICE REVENUE	(3) ADJ. & RECLASS.	= (4) NET PROVIDER REVENUE
RESIDENT REVENUES					
2120	Private Resident ICF/MR				
2140	Private Resident-Other (Sch. A)				
2250	Other Governmental Supported Resident (Sch.A)				
2320	Medicaid Resident - ICF/MR				
2400	Physical Therapy				
2410	Speech Therapy				
2420	Occupational Therapy				
2500	Nursing Supplies				
2510	Prescription Drugs				
2520	Laboratory				
2530	X-Ray				
2600	Barber & Beauty Shop				
2610	Personal Purchase Income				
2700	Miscellaneous Resident Revenue (Sch. A)				
OTHER REVENUE					
2800	Grants				
2810	Donations				
2820	Interest Income				
2830	Rental Income - Facilities & Equip.				
2840	Staff & Guest Food Sales				
2850	Concession Income				
2900	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) _____

SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) + FACILITY GROSS EXPENSE	(2) + HOME OFFICE EXPENSE	(3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
GENERAL & ADMINISTRATIVE					
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				
SHELTER					
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				
UTILITIES					
5610	Heating Oil				
5620	Gas				
5630	Electricity				
5640	Water, Sewage & Garbage				
	TOTAL UTILITIES				

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
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				

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE +	(2) HOME OFFICE EXPENSE +	(3) ADJUSTMENTS AND RECLASSIFICATION =	(4) NET ALLOWABLE EXPENSES
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				
9l24	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 (FSRTF only)				
9149	Salaries-Other (Sch. A)				
9296	Employee Benefits & Taxes;				
	TOTAL				

SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE +	(2) HOME OFFICE EXPENSE +	(3) ADJUSTMENTS AND RECLASSIFICATION =	(4) NET ALLOWABLE EXPENSES
ACTIVE TREATMENT SERVICES					
9150	Qualified Mental Retardation Professional				
9151	Registered Nurse Consultant (SRTF Only)				
9152	Psychologist				
9153	Social Worker				
9154	Speech Therapist				
9156	Occupational Therapist				
9157	Recreational Therapist				
9158	Physical Therapist				
9159	Dietitian				
9160	Dentist				
9161	Pharmacist				
9162	Skill Trainer/Program Coord.				
9170	Other Medical Consultants (Sch. A)				
9297	Employee Benefits & Taxes				
	TOTAL				
MEDICAL SERVICES (FSRTF only)					
9180	Physician Services				
9181	Pharmacy Services				
9182	Laboratory Services				
9183	X-Ray Services				
9186	Nursing Services				
9187	Dental Services				
9188	Central Supply Services				
9298	Employee Benefits & Taxes				
	TOTAL				
DAY PROGRAM SERVICES (FSRTF only)					
9190	Day Program Services				
9299	Employee Benefits & Taxes				
	TOTAL				
	TOTAL LABOR COSTS				
	TOTAL BASE & LABOR COSTS				

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE +	(2) HOME OFFICE EXPENSE +	(3) ADJUSTMENTS AND RECLASSIFICATION =	(4) NET ALLOWABLE EXPENSES
3211	FICA				
3212	State Unemployment				
3213	Federal Unemployment				
3214	Worker's Compensation				
3215	Tri-Met				
3216	Other (Specify)				
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.

BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) + FACILITY	(2) + HOME OFFICE	(3) = ADJ. & RECLASS.	(4) NET
1101	Cash on Hand				
1102	Cash in Bank				
1103	Cash in Savings				
1150	Accounts Receivable				
1160	Notes Receivable				
1169	Provision for Doubtful Accounts				
1170	Employee Advances				
1200	Inventory-Nursing Supplies				
1201	Inventory-Food				
1202	Inventory-Other				
1250	Prepaid Expenses (Sch. A)				
1270	Other Current Assets (Sch. A)				
1310	Land				
1320	Land Improvements				
1321	Accumulated Depreciation Land Improvements				
1330	Buildings				
1331	Accumulated Depreciation-Bldg.				
1340	Equipment-Bldg. Fixed				
1341	Accumulated Depreciation-Equip. Bldg.				
1350	Equipment-Moveable				
1351	Accumulated Depreciation - Equip. Moveable				
1370	Leasehold Improvements				
1371	Accumulated Amortization-Lease Improvements				
1400	Investments (Sch. A)				
1470	Other L/T Assets (Sch. A)				
	TOTAL ASSETS				

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) FACILITY	+	(2) HOME OFFICE	+	(3) ADJ. & RECLASS.	=	(4) NET
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							

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

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 ALLOCATION METHOD	ICF/MR	Level-of-Care Other (Specify)	Other (Specify)	Allocation Base	Net Cost Area Expense	Multiplier
Gen. & Admin. Resident Days						
Shelter Square Footage						
Utilities Square Footage						
Laundry Resident Days						
Housekeeping Square Footage						
Dietary Resident Days						
Nursing Supplies & Services Resident Days						
Admin. Salaries Resident Days						
Other Admin. Salaries Resident Days						
Nursing Salaries Actual Payroll						
Direct Care Salaries Actual Payroll						
Other Salaries Actual Payroll						
Active Treatment Services Actual Payroll						
Medical Services Actual Payroll						
Day Program Services Actual Payroll						
Return on Equity Resident Days						

ALLOCATED COSTS

Cost Areas	ICF/MR
BASE COSTS	
General & Administrative	
Shelter	
Utilities	
Laundry	
Housekeeping	
Dietary	
Nursing Supplies & Services	
TOTAL BASE COSTS	
LABOR COSTS	
Administrator Salaries	
Other Administrative Salaries	
Nursing Salaries	
Direct Care Salaries	
Other Salaries	
Active Treatment Services	
Medical Services	
Day Program Services	
TOTAL LABOR COSTS	
RETURN ON EQUITY	
GRAND TOTAL	

$$\frac{\text{GRAND TOTAL}}{\text{ICF/MR Resident Days}} = \underline{\qquad\qquad} \text{ ICF/MR Cost per Day}$$

SCHEDULE A

EXPLANATION OF MISCELLANEOUS ACCOUNTS

ACCT. #	EXPLANATION	AMOUNT	ACCT. #	EXPLANATION	AMOUNT

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

Resident Classification Report
Resident Days By Classification and B Level-Of-Care

Month ICF/MR

	A		A-I-3		S		B		C			Other
	AFS	Other	AFS	Other	AFS	Other	AFS	Other	AFS	Other	TOTAL	(Specify)
January												
February												
March												
April												
May												
June												
July												
August												
Sept.												
October												
Nov.												
Dec.												
TOTAL												

Month Resident Days by licensed Bed

	Designated ICF/MR Area			Other (Specify)	Other (Specify)
	AFS	Other	Total		
January					
February					
March					
May					
June					
July					
August					
Sept.					
October					
Nov.					
Dec					
TOTAL					

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

Bed Capacity

	Designated ICF/MR Area			Other (Specify)			Other (Specify)		
	Beginning	Change	Change	Beginning	Change	Change	Beginning	Change	Change
Licensed Bed Capacity									
Certificate of Need Capacity									
Available Capacity									
Date Changed									

STAFFING RATIO REPORT OR DIRECT CARE STAFF*

	SHIFT											
	1st				2nd				3rd			
MONTH	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.
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												

*Direct Care Staff - See ICF/MR Provider Guide for Definition.

STAFFING RATIO REPORT
FOR SECURE WARD STAFF

	SHIFT											
	1st				2nd				3rd			
	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	Sups.	Staff	Sups.	Staff.	Sups	Staff	Sups.	Staff	Sups.
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												

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.

(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.

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.

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 Heath 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.

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.

(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.

(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 impatient 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).

(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.

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:

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.

On a quarterly basis, the MMIS system produces a listing of all claims processed for recipients with third party resource coverage. This report includes all claims with a TPR explanation code. This report is used by the Utilization Review group to identify any fraudulent or erroneous billings through verification with the third party carriers.

2) The requirement in 433.139(f)(2) is met, as follows:

Threshold amounts. With the implementation of the Post Payment Recovery System the threshold amount for the post payment recovery of claims are:

A) For claims involving Medicare, zero.

B) For claims involving private health insurance, zero.

C) For drug claims, $25.

D) For ICF/MR and IMD, zero.

E) For claims paid under the provisions of 433.139(b)(3), zero.

3) The requirement in 433.139(f)(3) is met, as follows:

A) Oregon accumulates drug claims to $25 before billing. If the accumulated total is less than $25 for the 60 day period prior to the billing generation, the claims will be added to the next billing cycle (every 60 days for drug claims). For all other claim types, Oregon does not accumulate billings by dollar amount or period of time and the weekly Post Payment Recovery System billing cycle is run immediately following the weekly MMIS claims cycle. All recoveries are sought within the time limits specified in 433.139(d).

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.

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

U.S. Government Printing Office : 1991 - 312-149/40352

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.

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.

State/Territory: OREGON

Citation		
		Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)	(a)	The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are not concerning sanctions for psychiatric hospitals that do not meet the requirements of 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.
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

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.

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.

CHAPTER 761
AN ACT

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, chapter ___ 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:

POWER OF ATTORNEY FOR HEALTH CARE

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 heath are 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 direct that my attorney-in-fact comply with the following instructions or limitations: _____

In addition, I direct that my attorney-in-fact have authority to make decisions regarding the following.

____ Withholding or withdrawal of life-sustaining procedures with the understanding that death may result.

____ Withholding or withdrawal of artificially-administered hydration or nutrition or both with the understanding that dehydration, malnutrition and death may result.

_____
(Signature of person making appointment/Date)

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 principal's attending physician. Witnessed By:

(Signature of Witness/Date) (Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT POWER OF ATTORNEY

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.

(Signature of Attorney-in-fact/Date)

(Printed name)

_____
(Signature of Alternate Attorney-in-fact/Date)

(Printed name)

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

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.

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.

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 voluntary 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.[Formerly97.055]

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.

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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

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.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-110

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.

X 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.)

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.

X 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

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.

X 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

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.

X 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

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.

X 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

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.

STATE PLAN UNDER TITLE XIX OF TH3t SOCIAL SECURITY ACT

State/Territory: OREGON

DlSCLOSURE 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.

STATE PLAN UNDER TITLE XIX OF TH3t 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.

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.

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.

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).

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.

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.

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.

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.

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.

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 Departments oversight and compliance will begin upon receipt of notification or by September 30, 2007 which ever 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.

Attachment 5.1A

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

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 seg.) 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 diseased 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.

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 it's 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 POLI CY 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)

Regard1ng Title VI, where the primary objective of the federal financial assistance to an OHA Division is to provide employment, the responsible agency has develop 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,

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 readi1y accessible to and usable by persons with disabil1ties.

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.

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.

Section 8
ACA SPA

Refer to supersede pages to determine replacement pages

OMB 0938-1148

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. ☐ Yes ☒ No

Eligibility Groups - Options for Coverage

Reasonable Classification of Individuals under Age 21 S52

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
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.

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 as 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
☒ Individuals for whom public agencies are assuming full or partial financial responsibility	
☒ Individuals placed in foster care homes by public agencies	
Indicate the age which applies:	
☒ Under age 21 ☐ Under age 20 ☐ Under age 19 ☐ Under age 18	
☐ Individuals placed in foster care homes by private, non-profit agencies	
☒ Individuals placed in private institutions by public agencies	
Indicate the age which applies:	
☒ Under age 21 ☐ Under age 20 ☐ Under age 19 ☐ Under age 18	
☐ Individuals placed in private institutions by private, non-profit agencies	
☐ Individuals in adoptions subsidized in full or part by a public agency	

☒ 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
☐ 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 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:

☒ 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 faciltiies 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

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

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

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.

Eligibility Groups - Options for Coverage Children with Non IV-E Adoption Assistance S53
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. ☐ Yes ☒No

Eligibility Groups - Mandatory Coverage Former Foster Care Children S33
42 CFR 435.150 1902(a)(10)(A)(i)(IX)
☒ Former Foster Care Children - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care. ☒ The state attests that it operates this eligibility group under the following provisions: ☒ Individuals qualifying under this eligibility group must meet the following criteria: ☒ Are under age 26. ☒ 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. ☒ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program. The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system. ☐ Yes ☒ No 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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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

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 MAGIequivalent percent of FPL.

☒ 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

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 (lowincome 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 (lowincome families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty Levelrelated 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.

☐ 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:

☒ 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

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.

☒ 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

☐ Anotherincome 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

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

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

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

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

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

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

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

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

☒ 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

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.

☐ Yes ☒ No

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

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.

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

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

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

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.

MAGI-Based Income Methodologies	S10
1902(e)(14) 42 CFR 435.603	

☒ **T**he state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

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.

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.

In determining family size for the eligibility determination of the other individuals in a household that Includes a pregnant woman:

☐ The pregnant woman is counted just as herself.
☐ The pregnant woman is counted as herself, plus one.
☒ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

☒ Current monthly household income and family size
☐ Projected annual household income and family size for the remaining months of the current calendar year.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
☒ Account for a reasonably predictable decrease in future income and/or family size.

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

State Plan Administration
Designation and Authority A1

42 CFR 431.10

Designation and Authority

State Name: Oregon

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the 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 Department.

Name of single state agency: Oregon Health Authority
Type of Agency:
- ☐ Title IV-A Agency
- ☒ Health
- ☐ Human Resources
- ☐ Other
  - Type of Agency:

The above named 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.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:
ORS. 413.032
The single state agency supervises the administration of the state plan by local political subdivisions.
☐ Yes ☒ No
☒ 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.

Attachment submitted

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.
The single state agency administers the entire state plan under title XIX (i.e., no other or organization administers any portion of it).
☐ Yes ☒ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.
The waivers are still in effect.
☒ Yes ☐ No

Enter the following information for each waiver:

Date waiver granted (03/23/15):
The type of responsibility delegated is (check all that apply):
☐ Determining eligibility
☒ Conducting fair hearings
☐ Other
Name of state agency to which responsibility is delegated:
Office of Administrative Hearings (OAH)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

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.

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 (under State law) 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.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

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 or benefit service level appeals hearings request are assigned to OHA or DHS based upon MAGI or non-MAGI or a combination of both. The Oregon Health Authority, Office of Client & Community Service employees review the MAGI 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.

Oregon Health Authority will ensure that:
i. OHA retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by OAH.
ii . OHA will ensure that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact OAH and obtain information about fair hearings from that agency.
iii. OHA will ensure that OAH complies with all federal and state laws, regulations, policies and guidance applicable to the Medicaid program.

Date waiver granted (03/23/15):
The type of responsibility delegated is (check all that apply):

- ☐ Determining eligibility
- ☒ Conducting fair hearings
- ☐ Other

Name of state agency to which responsibility is delegated:

Department of Human Services

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Department of Human Services:

For non-MAGI eligibility cases, Department of Human Service (DHS) staff will review the hearing request, conduct the informal interview, and can issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws. DHS staff can perform the review of the hearing request, conduct the informal interview and can issue dismissal orders on eligibility or benefits unique to "home and community based care"/Title XIX services needed to keep an individual out of a long-term care facility. These services are: In-home services except for state plan personal care services.; Residential care facility services; Assisted living facility services; Adult foster care services; Home adaptations to accommodate a client's physical condition; Home-delivered meals provided in conjunction with in-home services; specialized living facility services; Adult day care services; Community transition services; personal care services for the Aged and Physically Disabled or Child Welfare non-MAGI populations. DHS employees participate in the hearing, and DHS have final order authority. If an individual has a combined hearing about both MAGI and non-MAGI eligibility, DHS employees may cover all issues in terms of participating in the hearing but OHA retains final authority over the final orders. If the matter goes to heanng, the heanng IS conducted by an Admm1stra11ve Law Judge (ALJ), employed by UAH. 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 or the Department of Human Services. Should Oregon Health Authority or the Department of Human Services disagree with the Office of Administrative Hearings, the Oregon Health Authority or the Department of Human Services may review the application/interpretation of laws, rules, and policies. If merited, the Oregon Health Authority or the Department of Human Services can change them.
However, the OAH/ALJ findings offact (under State law) 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.
Oregon Health Authority retains final authority over all eligibility and benefit fair 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 Department of Human Services.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

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 eligibility appeals hearings request are assigned to OHA or DHS based upon MAGI or non-MAGI or a combination of both. Service cases are assigned to OHA staff if the hearing is about medical or dental services. Services cases are assigned to DHS if the hearing is about developmental disability services, in-home services, or child welfare personal care services. The Oregon Health Authority, Office of Client & Community Service employees review a MAGI eligibility fair 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. The Department of Human Services employees review the non-MAGI eligibility fair 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, the Department of Human Service participates in the hearing in coordination with OHA. 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.

Oregon Health Authority will ensure ensure that:
i. OHA retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by DHS.
ii . OHA will ensure that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact DHS and how to obtain information about fair hearings from that agency.
iii. OHA will ensure that DHS complies with all federal and state laws, regulations, policies and guidance applicable to the Medicaid program.
iv. OHA has a Intergovernmental Agreements (IGAs) in place with the DHS. DHS is responsible for administrative or operational functions, including eligibility determinations as necessary and appropriate for the following Medicaid populations: Aged, Blind and Disabled, Child Welfare, Foster children and Adoption Assistance. OHA performs Medicaid eligibility determinations for all other populations.

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- ☒ The Medicaid agency
- ☐ 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 entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☒ The Medicaid agency
- ☒ 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

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☒ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

☒ Yes ☐ No

State Plan Administration
Organization and Administration A2

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 (OEBB); 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 six sub units, the sub units are made up of: Health Information Technology which manages the Medicaid EHR incentive program among other statewide HIT initiatives; Health Analytics which includes the management of metrics; Health Policy which includes Medicaid policy development and Clinical Improvement Services. Clinical Improvement Services oversees Quality Improvement, the Health Evidence Review Commission, the Pharmacy & Therapeutics Committee, and the Transformation Center; Public Benefit plans; and Business supports. These units are responsible to conduct health and drug evidence review, policy analysis, research, and evaluation, collect and analyze data and provide technical assistance to support health system reform planning and implementation; Develop health policy for physical health care, oral health care and behavioral health care; State plan and waiver administration.

Health Systems Division: has five sub units, the sub units are made up of: Member services; Providers services; compliance regulations; operations support and business systems support. These units are responsible to 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; manage call centers and MAGI-based eligibility determinations; implement policies for program eligibility; client services; outreach, eligibility hearings; 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 Medicaid populations: Aged, Blind and Disabled, Child Welfare, Foster children and Adoption Assistance. Oregon Health Authority performs Medicaid eligibility determinations for all other populations

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.

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.

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	

Assurances

☒ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☒ All requirements of 42 CFR 431.10 are met.

☒ 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.

☒ 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.

Assurance for states that have delegated authority to determine eligibility:

☒ 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).

Assurances for states that have delegated authority to conduct fair hearings:

☐ 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).

☐ 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.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☒ 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.

42 CFR 435.403

State Residency

☒ 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:

- ☒ 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:
  - ☒ Intends to reside in the state, including without a fixed address, or
  - ☒ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ☒ 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.
- ☒ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ☒ Residing in the state, with or without a fixed address, or
  - ☒ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ☒ 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:
  - ☒ 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
  - ☒ 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
  - ☒ 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.
- ☒ 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.
- ☒ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ☒ 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.
- ☒ IV-E eligible children living in the state, or
- ☒ Otherwise meet the requirements of 42 CFR 435.403.

Meet the criteria specified in an interstate agreement.

☒ Yes ☐ No

☒ The state has interstate agreements with the following selected states:

☒ Alabama	☒ Illiois	☒ Montana	☒ Rhode Island
☒ Alaska	☒ Indiana	☒ Nebraska	☒ South Carolina
☒ Arizona	☒ Iowa	☒ Nevada	☒ South Dakota
☒ Arkansas	☒ Kansas	☒ New Hampshire	☒ Tennessee
☒ California	☒ Kentucky	☒ New Jersey	☒ Texas
☒ Colorado	☒ Louisiana	☒ New Mexico	☒ Utah
☒ Connecticut	☒ Maine	☐ New York	☒ Vermont
☒ Delaware	☒ Maryland	☒ North Carolina	☒ Virginia
☒ District of Columbia	☒ Massachusetts	☒ North Dakota	☒ Washington
☒ Florida	☒ Michigan	☒ Ohio	☒ West Virginia
☒ Georgia	☒ Minnesota	☒ Oklahoma	☒ Wisconsin
☒ Hawaii	☒ Mississippi	☐ Oregon	☐ Wyoming
☒ Idaho	☒ Missouri	☒ 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

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☒ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens 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.

☒ The state provides Medicaid eligibility to otherwise eligible individuals:

☒ Who are citizens or nationals of the United States; and

☒ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

☒ Who have declared themselves to be citizens or nationals of the United States, or an individual 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, 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.

The agency provides for an extension of the reasonable opportunity period if the individual 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

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

☒ Yes ☐ No

The date benefits are furnished is:

☒ The date of application containing the declaration of citizenship or immigration status.

☐ The date the reasonable opportunity notice is sent.

☐ Other date, as described:

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

☒ Yes ☐ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

☒ Yes ☐ No

- ☐ Pregnant women
- ☒ Individuals under age 21:
  - ☐ Individuals under age 21
  - ☐ Individuals under age 20
  - ☒ Individuals under age 19

☒ 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.

☒ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
2. Is 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));
3. Is 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;
4. Is a non-citizen who belongs to one of the following classes:
   - ☒ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
   - ☒ 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;
   - ☒ Granted employment authorization under 8 CFR 274a.12(c);
   - ☒ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
   - ☒ Under Deferred Enforced Departure (DED) in accordance with a decision made bythe President;
   - ☒ Granted Deferred Action status;
   - ☒ Granted an administrative stay of removal under 8 CFR 241;
   - ☒ Beneficiary of approved visa petition who has a pending application for adjustment of status;
5. 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 -
   - ☒ Has been granted employment authorization; or
   - ☒ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. 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));

10. 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 (1) through (9) of this definition.

☐ Other

☒ 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:

☒ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

☒ 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).

Presumptive Eligibility by Hospitals	S21
42 CFR 435.1110	

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.
☒ Yes ☐ No

☒ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☒ A qualified hospital is a hospital that:

☒ Participates as a provider under the Medicaid 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.

☒ 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.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.
☒ Yes ☐ No

☒ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ☒ Pregnant Women
- ☒ Infants and Children under Age 19
- ☒ Parents and Other Caretaker Relatives
- ☒ Adult Group, if covered by the state
- ☒ Individuals above 133% FPL under Age 65, if covered by the state
- ☒ Individuals Eligible for Family Planning Services, if covered by the state
- ☒ Former Foster Care Children
- ☒ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.
☒ Yes ☐ No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regularapplication, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards

The State will implement standards to assess:
1) The number of PE applications submitted;
2) The proportion of those individuals approved for PE that complete and submit an application for full ongoing coverage;
3) The proportion of those individuals approved for PE and that complete and submit an application for full ongoing coverage who are determined eligible for full ongoing benefits;
4) The accuracy of Hospitals' determination that applicants do not have coverage;
5) The accuracy of Hospitals' determination that applicants do not have a prior period of PE in the preceding twelve month period.

Given that criteria from current PE states are either inconsistent or otherwise not proven, the State will collect and require Hospitals to collect baseline data for up to 12 months in order to determine effective criteria.

Initial standards, therefore, will be attached to data collection and reporting and will require 100% compliance from any Hospital that wishes to continue as a qualified PE determination entity.

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4) The accuracy of Hospitals' determination that applicants do not have coverage;
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Given that criteria from current PE states are either inconsistent or otherwise not proven, the State will collect and require Hospitals to collect baseline data for up to 12 months in order to determine effective criteria.

Initial standards, therefore, will be attached to data collection and reporting and will require 100% compliance from any Hospital that wishes to continue as a qualified PE determination entity

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: Same as above

☒ The presumptive period begins on the date the determination is made.
☒ 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.

☒ Periods of presumptive eligibility are limited as follows:
- ☒ No more than one period within a calendar year.
- ☐ No more than one period within two calendar years.
- ☐ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- ☐ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.
☒ Yes ☐ No
- ☐ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- ☒ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Attachment submitted

☒ The presumptive eligibility determination is based on the following factors:
- ☒ 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)
- ☒ 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.
- ☒ State residency
- ☒ Citizenship, status as a national, or satisfactory immigration status

☒ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

Attachment submitted