HEALTH SYSTEMS DIVISION
Tina Kotek, Governor

Oregon Health Authority

500 Summer St NE, E35
Salem, Oregon 97301
Voice 503-945-5772
Fax 503-947-1119
TTY 711
www.oregon.gov/OHA

June 7, 2023

Centers for Medicare and Medicaid
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBJECT: Medicaid State Plan Amendment OR-23-0017

During the COVID-19 pandemic the Oregon Health Authority (OHA) submitted several 1135 Disaster relief state plan amendments. These 1135 Disaster relief state plan amendment provisions expired on 5/11/23 and one of those SPAs, 22-0022 reflected a rate model for the 1915(k) state plan designed to refine Oregon's developmental disabilities system to be more person centered. OHA intends to extend these rates indefinitely past the Public Health Emergency period.

Tribal consultation:
Oregon tribal entities were consulted in the submission of this SPA utilizing the regular Dear Tribal Leader Letter (DTLL) process. The DTLL was distributed to the Tribes on March 9, 2023. There was not a request for additional face-to-face discussion related to this SPA nor any comments or questions during the consultation period.

Public notice requirement:
Under the requirements of 42 CFR 447.205, notice is required for changes in reimbursement methods. A Public notice was posted March 7, 2023 and can be accessed on the states web at https://www.oregon.gov/oha/HSD/OHP/Pages/Meetings.aspx.

Should you have any questions, please contact Jesse Anderson via email at jesse.anderson@oha.oregon.gov.

Sincerely,

Dana Hittle
State Medicaid/CHIP Director
Oregon Health Authority

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER ___ ___ — ___ ___ ___ ___

2. STATE ___ ___

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY_____ $ _____
b. FFY_____ $ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT

10. GOVERNOR'S REVIEW *(Check One)*

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

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 May 12, 2023**. Rates are published at: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Documents/ODDS-Expenditure-Guidelines.pdf

The following 1915(k) provider types are reimbursed in the manner described:
Assisted Living Facility- Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:

Level 1 -- All individuals qualify for Level 1 or greater.

Level 2 -- Individual requires assistance in cognition/behavior AND elimination or mobility or eating.

Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

Level 5 -- Individual is full assist in three to six activities of daily living OR full assist in cognition/behavior AND one or two other activities of daily living.

Behavioral Support Consultants- DHS developed rates for Behavioral Coaches and Behavioral Consultants based on the usual and customary charges for similar services provided within Oregon.
Community Transition Providers- Payments are based on lowest market rate as evidenced by at least three bids.