

## **Table of Contents**

**State/Territory Name: Oregon**

**State Plan Amendment (SPA) #: 23-0028**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD 21244-1850



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**Financial Management Group**

January 17, 2024  
Dana Hittle, Director  
Oregon Health Authority  
500 Summer Street Northeast, E-15  
Salem, Oregon 97301-1079

RE: Oregon State Plan Amendment (SPA) 23-0028

Dear Director Hittle:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 23-0028 effective for services on or after September 1, 2023. The proposed amendment modifies the criteria for the Nursing Facility bariatric staffing standards.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act. We hereby inform you that Medicaid State plan amendment 23-0028 is approved effective September 1, 2023. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Diana Dinh at [Diana.Dinh@cms.hhs.gov](mailto:Diana.Dinh@cms.hhs.gov).

Sincerely,

A handwritten signature in cursive script that reads "Rory Howe".

Rory Howe  
Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI
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TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
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5. FEDERAL STATUTE/REGULATION CITATION
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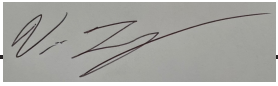
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
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8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
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9. SUBJECT OF AMENDMENT
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10. GOVERNOR'S REVIEW (Check One)	OTHER, AS SPECIFIED:
GOVERNOR'S OFFICE REPORTED NO COMMENT	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

11. SIGNATURE OF STATE AGENCY OFFICIAL 
12. TYPED NAME
13. TITLE
14. DATE SUBMITTED

15. RETURN TO
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<b>FOR CMS USE ONLY</b>	
16. DATE RECEIVED	17. DATE APPROVED

<b>PLAN APPROVED - ONE COPY ATTACHED</b>	
18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL <i>Rory Howe</i>
20. TYPED NAME OF APPROVING OFFICIAL	21. TITLE OF APPROVING OFFICIAL

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.
3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

D. Bariatric Rate.

1. Bariatric rate means the statewide payment for all long term care services provided to a Medicaid bariatric consumer who has a physician diagnosis of obesity with BMI > 40; and meets the following criteria as defined in OAR 411-015:
  - (a) Two-person full assist with ambulation or transfers; and
  - (b) Full assist in one of the following: cognition, eating or elimination.
2. If a Medicaid resident of a nursing facility qualifies for payment at the bariatric rate and meets the requirements described in paragraph 1 of the subsection, the Division will pay the bariatric rate stated in Section III.B.1.d.
3. If a Medicaid individual meets the criteria listed in paragraph 1 of this subsection, and the Division has authorized the bariatric rate, the nursing facility must provide one (1) additional Certified Nursing Assistant, above the licensing staffing standard, for the third through fifth approved individuals for the bariatric rate. Another Certified Nursing Assistant is then required for every additional five (5) individuals receiving the bariatric rate.
4. The Bariatric Rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for the services necessary to accommodate the needs of a bariatric person. The methodology for calculating the Bariatric Rate is described in Section III.