

## Public notice

### Notice of intent – OHA will amend the 1915(i) section of Medicaid State Plan.

**Date:** Jan. 14, 2025

**Contact:** Jesse Anderson, State Plan manager

**Comments due:** 5 p.m. Friday, Feb. 7, 2025

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Oregon Health Authority (OHA) intends to submit a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services to update the 1915(i) section of the Medicaid State Plan. Revisions include:

- New description of the tool used for functional needs assessments,
- Updating unit names and Oregon Administrative Rule citations, and
- Replacing some older criteria with new criteria for certain conditions.

There is no estimated cost to make these technical changes as they do not change reimbursement methods or benefits.

#### Obtaining SPA language

The next pages show edits to existing State Plan language in the proposed SPA. You can also view the full State Plan, approved SPAs and proposed SPAs on [the OHA website](#).

#### How to comment:

OHA welcomes public review and input. Please send written comments by 5 p.m. Friday, Feb. 7, 2025, to [jesse.anderson@oha.oregon.gov](mailto:jesse.anderson@oha.oregon.gov).

<input type="checkbox"/>	Specify the §1915(b) authorities under which this program operates ( <i>check each that applies</i> ):			
	<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
	<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
	<input type="checkbox"/>	<b>A program operated under §1932(a) of the Act.</b> Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:		
	<input checked="" type="checkbox"/>	<b>A program authorized under §1115 of the Act.</b> Specify the program: Oregon Health Plan		

**3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (Select one):**

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program ( <i>select one</i> ):	
	● The Medical Assistance Unit ( <i>name of unit</i> ):	Health Systems Medicaid Division
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit ( <i>name of division/unit</i> ) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
○	The State plan HCBS benefit is operated by ( <i>name of agency</i> )	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

- 3. Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The IQA receives requests for eligibility determinations for individuals who are potentially eligible for 1915(i) HCBS services from a referrer.

IQA conducts an in-person assessment/reassessment with the individual, the individuals authorized or legal representative or guardian, if applicable, and in consultation with any other persons identified by the individual, such as, but not limited to, the spouses, family, friends, providers, and treating and consulting health and support professionals responsible for the individuals care to determine if an individual is eligible for 1915(i) HCBS services based on the diagnostic and needs-based criteria.

~~The tools utilized identify the individual's service and support needs are the Level of Care Utilization System (LOCUS) and the Level of Service Inquiry (LSI).~~ The IQA will use an OHA approved, reliable and valid functional needs assessment tool. Completion of these tools, along with the IQA's review and consideration of all pertinent and necessary information, and consultation with the parties identified above result in the IQA's development of the individual's person-centered service plan.



7.  **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (Specify target group(s)):

Persons who are twenty-one years of age or older with a chronic mental illness or serious persistent mental illness (SMPI).

Pursuant to ORS 426.495 and Oregon Administrative Rule ~~410-173-0005~~309-019-0225, a person with a Serious and Persistent Mental ~~chronic mental illness~~ means an individual who is diagnosed by a psychiatrist, a licensed clinical psychologist, a licensed independent practitioner as defined in ORS 426.005 or a nonmedical examiner certified by the Oregon Health Authority or the Oregon Department of Human Services, as meeting the current DSM diagnostic criteria for at least one of the following conditions: Schizophrenia spectrum and other psychotic disorders, depressive disorders, bipolar and related disorders, Obsessive Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD) and Other Specified Trauma- and Stressor-Related Disorder due to cultural syndromes, or borderline personality disorder. ~~as having chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder other than those caused by substance abuse.~~

- Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

8.  **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).



**Methods and Standards for Establishing Payment Rates**

HCBS Habilitation (Cont)

- Adult Foster Homes-Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Oregon Health Authority with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

An individual’s assessed needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, the level of need is determined through standardized assessment tools, LOCUS and LSI assessment tools, along with on consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need.

Payment for services provided in the following DHS-licensed/certified community-based residential settings will be made using the approved rate methodology for services provided in these settings under the 1915(k) Community First State Plan Option and as described below:

- Assisted Living Facility - Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual’s assessed needs. An Independent and Qualified Agent conducts the needs assessment using the standardized LOCUS and LSI assessment tools ~~and for individuals enrolled in 1915(i) are the LOCUS and LSI assessments, along with in~~ consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records. The individual’s needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual’s acuity and ADL needs as follows:
  - Level 1 - All individuals qualify for Level 1 or greater.
  - Level 2 - Individual requires assistance in cognition/behavior AND elimination or mobility or eating.
  - Level 3 - Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>
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State: Oregon  
 TN:25-0003  
 Effective: 1/1/25

§1915(i) State plan HCBS  
 Approved:

Attachment 4.19-B  
 Page 45  
 Supersedes:21-0003

**Methods and Standards for Establishing Payment Rates**

<input checked="" type="checkbox"/>	<p>HCBS Habilitation (Cont)</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>• Group Care Homes for Adults - Each individual's support needs be assessed using a functional needs assessment annually, when an individual request's it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual person-centered planning meetings, and when there are changes to the person's condition:             <ul style="list-style-type: none"> <li>▪ The functional needs assessment collects information about the person's support needs. This information is used to match the individual with one of several levels of expected support need. For individuals enrolled in 1915(i), <del>standardized the LOCUS and LSI</del> assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment.</li> <li>▪ A funding tier is assigned. Each funding tier corresponds to the functional needs assessment derived expected support levels.</li> <li>▪ 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.</li> </ul> </li> <li>• State Operated Group Care Homes for Adults - Each individual's support needs are assessed using a functional needs assessment. For individuals enrolled in 1915(i) services, <del>standardized the LOCUS and LSI</del> assessment tools, <del>along with in</del> consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual eligibility redeterminations, annual person-centered service plan meetings, and when there are changes to the person's condition.</li> </ul>
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**Methods and Standards for Establishing Payment Rates**

HCBS Habilitation (Cont)

- State Operated Group Care Homes for Adults – (Cont) The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that DHS and OHA can assure that the total funding does not exceed the cost of operating the site.
- Residential Care Facility Regular - Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. For individuals enrolled in 1915(i) services, ~~standardized the LOCUS and LSI~~ assessment tools, ~~along with in~~ consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the APD functional needs assessment to determine the base rate and any potential add-ons. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if:
  - (A) The individual is full assist in mobility or eating or elimination;
  - (B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or
  - (C) The individual's medical treatments, as documented in the needs assessment, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.
- Residential Care Facility Contract - Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:
  - Supplemented Program Contract (as referred to in 1915(k) state plan): Allows an enhanced rate for additional services in excess of the published rate schedule to providers in return for additional services delivered to target populations.

**Methods and Standards for Establishing Payment Rates**

<input checked="" type="checkbox"/>	HCBS Habilitation (Cont)
	<ul style="list-style-type: none"><li>• Residential Care Facility Contract – (Cont)<ul style="list-style-type: none"><li>▪ Residential Care Facility Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of individuals whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population.</li></ul></li> <li>• APD Adult Foster Care - Medicaid reimbursement rates for Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process. An individual’s assessed needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, <del>standardized the LOCUS and LSI</del> assessment tools, <del>along with in</del> consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need.</li></ul> <p>Except as otherwise noted in the plan, state-developed fee methodology rates are the same for both governmental and private providers of HCBS habilitative services. The provider types, can bill, depending on the services provided, in 15-minute units, daily or monthly frequency, accordingly to the CPT/HCPCS billing code utilized. HSD will periodically audit the providers to ensure the appropriateness of the rates. Rate reviews are conducted continuously, and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third-party administrator.</p>
<input type="checkbox"/>	HCBS Respite Care