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

1. Inpatient Hospital Services

P&I The following service limitations will sunset on June 30, 2007.

P&I Individuals under the age of 21 have no hospital benefit day limits. Medicare Beneficiaries have no hospital benefit day limits. All other individuals are limited to 18 hospital benefit days per fiscal year in hospitals receiving DRG reimbursements. Inpatient days covered by other insurance are counted as hospital benefit days used when OMAP processes the claim.

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 Physician 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 Physician Care or Health Maintenance 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.

LIMITATIONS OF SERVICES (Continued)

b. Rural Health Clinic Services

Rural Health Clinic Services (RHC) is limited to otherwise covered services provided by licensed physicians and/or certified nurse practitioners in Rural Health Clinics certified by the Department of Health and Human Services. In addition to the above provider types, Maternity Case Management (MCM) services provided through a Rural Health Clinic may be provided by physician assistant, certified nurse midwife, direct entry midwife, social worker, or a registered nurse with a minimum of two years related and relevant work experience employed by the Rural Health Clinic. Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

c. Federally Qualified Health Center (FQHC) Services

Limited to ambulatory services

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 MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

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

Provided: _ No limitations X 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 X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a ~~skilled~~ nursing facility or elsewhere.

Provided: X _ 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 X 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 X With limitations*

_ Not provided

* Description provided on Attachment.

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 at age 18 months.

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 Office of Medical Assistance Programs medical or dental consultants.

4.c. Family Planning Services

Family planning services 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.

LIMITATIONS ON SERVICES

5.a. and b. Physicians Services

Payment for physician services is subject to published rules and instructions, and prior authorization of selected elective rehabilitative procedures. Other selected procedures are not covered based upon unproven efficacy and/or non-coverage by Medicare and other major third party payors, and after concurrence by appropriate provider representation. The OMAP Medical-Surgical Services guide sets forth the procedures for which payment will not be made, for which prior authorization is required, or for which other program controls are applied. All rules and instructions governing billing and payment are set forth in the guide. The Current Procedural Terminology (CPT) and HCPCS codes are the basis of medical terminology and procedure descriptions.

Reimbursement for non-emergency services provided by out-of-state physicians, other than in contiguous areas, must be prior authorized. However, 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 or Canada is on the same basis as services provided in Oregon.

The Division may disallow payment for physicians' services provided during impatient hospitalizations in which prior approval was required by not obtained.

Dental hygienists are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Denturists are covered for services within their scope of practice as defined in Oregon Revised Statutes.

6.a. Podiatrist Services

Payment for podiatrist services is on the same basis as physician services, except that maximum fees allowable for medicine and surgery procedures will be at a percentage of the maximum allowable for physician services. Fees for lab and X-ray procedures are at the same level as for physicians and independent clinical labs. Selected procedures require prior authorization of payment. Routine foot care is excluded from coverage.

LIMITATIONS ON SERVICES (Cont.)

6.b. Optometrist Services

Optometrist services are provided subject to rules and procedures set forth in the OMAP Visual Services Guides. Prior authorization of payment is required for certain services as indicated in the appropriate guide.

6.c. Chiropractor Services

Chiropractic Services provided are limited to persons under age 21 as part of the EPSDT benefit. Chiropractor Services provided are subject to OMAP rules and procedures set forth in the appropriate provider guide.

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.

LIMITATIONS ON SERVICES (Cont.)

6.d. Other Practitioner Services

Naturopaths are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Direct Entry midwives are covered for services within their scope of practice as defined in Oregon Revised Statutes.

Acupuncturists are covered for services within their scope of practice as defined in Oregon Revised Statutes.

7.a. Home Health Care Services

Intermittent or part-time nursing services are provided according to a plan of treatment. OMAP Home Health Care Services Guide describes services provided, prior authorization requirements, and limitations of services and payments.

Intermittent or part-time nursing services of a professional licensed practical nurse or registered nurse when no home health agency is available are provided according to a plan of treatment. OMAP Home Health Care Services Guide and OMAP Private Duty Nursing Services Guide describe services provided, prior authorization requirements, and limitations on services and payments.

7.b. Services of Home Health Aide

Services of a home health aide giving personal care are provided according to a plan of treatment. OMAP Home Health Care Services Guide describes services provided, prior authorization requirements, and limitations of services and payments.

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

Medical supplies, equipment and appliances for use of the patient in their own home are provided. OMAP Durable Medical Equipment and Medical Supplies Guide and Home Health Care Services Guide describe services provided, prior authorization requirements, and limitations of services and payments.

LIMITATIONS ON SERVICES (Cont.)

7d. Physical, Occupational, Speech Therapy in Patient's Home

Physical therapy, occupational therapy, and speech pathology are provided according to a plan of treatment. OMAP Home Health Care Services Guide describes services provided, prior authorization requirements, and limitations of services and payments.

8. Private Duty Nursing Services

Private duty nursing services are provided according to a plan of treatment. OMAP Private Duty Nursing Services Guide and the Medically Fragile In-Home Supports Oregon Administrative Rules describes services provided, prior authorization requirements, and limitations of services and payments.

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.

LIMITATIONS ON SERVICES

9. Clinic Services

Payment for clinic services is in accordance with 42 CFR 440.90, and is subject to published rules and instructions, and prior authorization of payment for selected elective and rehabilitative procedures. Other selected procedures are not covered based on unproven efficacy and/or non-coverage by Medicare and other major third party payers, and after concurrence by appropriate provider representation. The AFS practitioner services guides set forth the procedures for which payment will not be made, for which prior authorization is required, or for which other program controls are applied. All rules and instructions governing billing and payment are set forth in the guides. The Current Procedural Terminology (CPT) and HCPCS codes are the basis for medical terminology and procedure descriptions.

Reimbursement for non-emergency services provided by out-of-state clinics, other than in contiguous areas, must be prior authorized. However, payment for services to foster children and children in subsidized adoption who are placed by the Children's Services Division anywhere in the United States or Canada is made on the same basis as services provided in Oregon.

LIMITATIONS ON SERVICES (Cont.)

10. Dental Services

Dental Services provided for adults and children are:

- Preventive services
- Dental examinations
- Restorative services (filings, crowns)
- Diagnostic services (radiology/diagnostic imaging/oral pathology) that are medically and dentally necessary
- Periodontics
- Endodontics
- Oral and Maxillofacial Surgery
- Orthodontics
- Adjunct services

Dental Services provided for children only are:

- EPSDT services

For adults and children service authorization requirements and limitations of services are subject to Oregon Administrative rule and the 1115 demonstration waiver.

11a. Physical Therapy

Physical therapy is provided according to a plan of treatment. OMAP Physical and Occupational Therapy Guide describes services provided, prior authorization requirements, and limitations of services and payments.

11b. Occupational Therapy

Occupational therapy is provided according to a plan of treatment. OMAP Physical and Occupational Therapy Guide describes services provided, prior authorization requirements, and limitations of services and payments.

LIMITATIONS ON SERVICES (Cont.)

11c. Services for Individuals with Speech, Hearing and Language Disorders

Speech pathology or audiology services are provided according to a plan of treatment. OMAP Speech-Language Pathology, Audiology and Hearing Aid Services Guide describes services provided, prior authorization requirements, and limitations of services and payments.

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.

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 Department will maintain a list of drugs to be referred to as the Practitioner Managed Prescription Drug List (PDL). The PDL is a listing of prescription drugs that the Department has determined represents the most effective drug(s) at the best possible price for the selected drug classes. The PDL will include other drugs in the class that are Medicaid reimbursable and which the FDA has determined to be safe and effective if the relative cost is less than the benchmark drug(s). When pharmaceutical manufacturers enter into supplemental rebate agreements with DHS that reduces the cost of their drug below that of the benchmark drug for the class, their drug will also be included in the PDL. The PDL is developed with a governor appointed committee, the Health Resource Commission (HRC), in coordination with the Drug Utilization Review Board. The HRC conducts an evidence-based evaluation of selected classes of prescription drugs covered by the Department. The HRC will make drug effectiveness recommendations to the Department.

A practitioner may prescribe any Medicaid reimbursable, FDA approved drug that is not listed on the PDL. If the practitioner in the exercise of professional judgement considers it appropriate for the diagnosis or treatment and is within the practitioner's scope of practice, he/she may prescribe a non-PDL drug by notating such anywhere on the prescription. Regardless of the PDL, prescriptions shall be dispensed in the generic form unless practitioner requests otherwise subject to the regulations outlined in 42 CFR 447.331, ORS 689.515.

The state utilizes The Oregon State University College of Pharmacy for literature research and the state DUR (Drug Utilization Review) Board 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 prior authorization process provides prescribing physicians, pharmacists, and/or designated representatives the ability to contact the Medicaid PA unit via a toll free telephone or other telecommunication device. Responses are issued within 24 hours of the prior authorization request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product 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.

LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

CMS is approving a rebate agreement between the state and a drug manufacturer that provides supplemental rebates for drugs provided to the Medicaid program, submitted to CMS on 6/19/2003 and entitled, "State of Oregon, Supplemental Rebate Agreement".

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

LIMITATIONS ON SERVICES (Cont.)

12a. Prescribed Drugs (Cont.)

340BProgram:

A program to be phased in starting with a single clinic and adding covered entities if program is determined to be successful. The program will subscribe to all federal and state regulations and adhere to HRSA guidelines for operating a contract pharmacy, including product ownership and ordering, billing and reconciliation, and audit process elements. Covered entities and their contract pharmacies will establish and maintain a tracking system suitable to prevent diversion thus ensuring that (1) only eligible patients of the covered entity receive medications, (2) only eligible Medicaid patient prescriptions are reimbursed by the Department, and (3) duplicate discounting from State Medicaid rebate formulations is prevented.

LIMITATIONS ON SERVICES (Cont.)

12.b. Dentures

Dentures are limited for adults.
Dentures are covered for children under the EPSDT Program.

12.c. Prosthetic Devices

Prosthetic devices are provided. OMAP Durable Medical Equipment and Medical Supplies rules describes services provided, prior authorization requirements and limitations of services.

12.d. Eyeglasses

P&I The following service limitation will sunset on June 30, 2007.

Except for pregnant women and children, OMAP limits coverage of refractive lenses to lenses used to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens because of surgical removal or congenital absence, and for conditions specified in administrative rules. Service authorization requirements and limitations of services are specified in rule.

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:

(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.

LIMITATION ON SERVICES

13.d. Rehabilitative Mental Health Services

Mental health rehabilitative services include coordinated assessment, therapy, daily structure/support, consultation, medication management, skills training and interpretive services. The Mental Health and Developmental Disability Services 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 Comprehensive Services Providers (CSPS) or Mental Health 0rganizations (MHOs). The CSPs or MHOs may provide services directly, or through subcontract providers, in a variety of settings. For CSP subcontract providers, the Division must grant a certificate of approval for the scope of services to be reimbursed.

Licensed Medical Practitioners (LMPs), defined below, provide ongoing medical oversight. LMPs document the medical necessity and appropriateness of services by approving comprehensive mental health assessments and individualized treatment plans at least annually.

Clinical Supervisors, defined below, provide documented clinical oversight, at least every three months, of the effectiveness of mental health treatment services delivered by Qualified Mental Health Associates (QMHAs) and by Qualified Mental Health Professionals (QMHPs).

An "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. 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.

A "Clinical Supervisor" means a 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.

A "QMHP" means 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; and
7. 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.

A "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.

Only LMPs, QMHPs, or QMHAs may deliver the mental health treatment services specified in the Division's Rehabilitative Services Payment Schedule.

STATE OF OREGON

LIMITATION ON SERVICES

13.d. Rehabilitative Alcohol & Drug Services

Alcohol and drug rehabilitative services are provided upon recommendation of a physician to eligible clients through comprehensive agencies or facilities granted a Letter of Approval by the Office of Alcohol and Drug Abuse Programs, Department of Human Resources. The services to be provided include assessment, outpatient treatment, methadone dispensing, treatment monitoring, consultation, and acupuncture.

The services will be provided by any person meeting the following minimum qualifications:

Physician licensed to practice in Oregon;

Graduate Degree in Psychology;

Graduate Degree in Social Work;

Graduate Degree in Nursing and licensed in the State of Oregon;

Acupuncturist licensed to practice in Oregon;

Any other person whose education and experience meet the standards and qualifications established by the State Office of Alcohol and Drug Abuse Programs through administrative rule.

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.

STATE OF OREGON

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] 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.

LIMITATIONS ON SERVICES (Cont'd)

18. Hospice Care

Hospice care services arc provided for physician-certified terminal illnesses subject to the waiver demonstration approved Prioritized List of Health Services and service limitations in administrative rules. Hospice services include acute, respite, home care and bereavement services provided to meet the physical, psychosocial, spiritual. and other special needs of the patient during the final stages of illness, dying and bereavement period. This includes pain and symptom management and palliative services. Administrative rules require the use of a Medicare certified hospice unless one is not available in the area, in which case a hospice accredited. by the Oregon Hospice Association is allowed to be used. Oregon Administrative Rules require the following: No payment will be made for room and board. However, if an individual resides in a nursing facility and elects hospice, the hospice will bill Medicaid for the hospice care provided and for the cost of room and board (no less than 90% of the nursing facility per diem rate). Upon receipt of the reimbursement for the cost of the room and board. the hospice provider will forward to the nursing facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory OREGON

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
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.

LIMITATIONS ON SERVICES

20.a. Extended Services to Pregnant Women

Pregnancy-related and post-partum services provided for 60 days after the pregnancy ends include:

1. Major categories of service:

   a. inpatient hospital services, with the limitations specified in Attachment 3.1-A, page l.a;
   b. outpatient hospital services, with the limitations specified in Attachment 3.1-A, page l.a;
   c. laboratory and X-ray services, with limitations specified in Attachment 3.1-A, page l.b;
   d. physician services, with the limitations specified in Attachment 3.1-A, page 2.a;
   e. clinic services, with limitations specified in Attachment 3.1-A, page 4.a;
   f. prescribed drugs, with limitations specified in Attachment 3.1-A, page 5.a;
   g. diagnostic services;
   h. nurse-midwife services, with limitations specified in Attachment 3.1-A, page 7.a;
   i. transportation, with limitations specified in Attachment 3.1-A, page 7.a;
   j. all emergency medical services.

2. Additional Services to Pregnant Women:

   a. An initial needs assessment to assess the basic needs of the expectant mother, provided by a licensed physician, physician's assistant, nurse practitioner, social worker, or a registered nurse with a minimum of two years of experience, or by an individual under the supervision of one of the above practitioners.

   b. Ongoing case management including development and monitoring to assist the expectant mother in obtaining and effectively utilizing the necessary health and related social services, provided by provider of a type described in Attachment 3.1-A, page 8a Section 20.a.2.a.

LIMITATIONS ON SERVICES

20.a. Extended Services to Pregnant Women

2. c. High risk management provided to expectant mothers, identified as being at risk for a low birth weight baby who have demonstrated an inability to follow medical treatment and other service plan parameters. Identification of risk will be made by a licensed physician or nurse practitioner with services provided by a provider of a type described in Attachment 3.1a, page 8a Section 20.a.2a.

d. Nutritional counseling for expectant mothers who have clinical indications identified and for which adequate services are not available from a local Women Infants and Children Program (WIC), provided by a registered dietician, or; an individual with a bachelor's degree in a nutrition related field with two years of related work experience.

e. Home visits, requiring a home assessment and specified training and education, are available to all pregnant women. These services are limited to a maximum of four home visits per pregnancy. These services can be provided by any provider qualified for Maternity Case Management Services.

b. Services for any other medical conditions that may complicate pregnancy include:

1. Major categories of services:

a. inpatient hospital services, with the limitations specified in Attachment 3.1-A, page 1.a;

b. outpatient hospital services, with the limitations specified in Attachment 3.1-A, page l.a;

c. rural health clinic services and other ambulatory services, with limitations specified in Attachment 3.IA, page 1.b;

d. laboratory and X-ray services, with limitations specified in Attachment 3.1-A, page l.b;

e. physician services, with the limitations specified in Attachment 3.1-A, page 2.a;

f. home health services, with limitations specified in Attachment 3.1-A, page 2.a.;

LIMITATIONS ON SERVICES (cont.)

g. private duty nursing services, with limitations specified in Attachment 3.1-A, page 3.a;

h. clinic services,, with limitations specified in Attachment 3.1-A, page 4.a;

I. physical therapy and related services, with limitations specified in Attachment 3.lA, page 4.b;

j. prescribed drugs with limitations specified in Attachment 3.1-A: page 5.a;

k. diagnostic services;

l. nurse-midwife services, with limitations specified in Attachment 3.1-A, page 7.a;

m. transportation, with limitations specified in Attachment 3.1-A, page 7.a.;

n. all emergency medical services.

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.

LIMITATIONS ON SERVICES (Cont.)

24.a. Transportation

All non-emergency medical transportation requires authorization of payment for medical appropriateness to a medical service covered under the Medical Assistance Programs. Non-emergency transportation for full-benefit dual eligible beneficiaries to obtain their Part D prescription drugs requires authorization of payment, and non-emergent transportation may be provided whether or not the prescription drug is covered under the Medical Assistance Programs.

P&I

Authorization of payment is not required for emergency transportation.

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.

LIMITATIONS ON SERVICES

24f. Personal Care Services (42 CFR 440,170(f))

Specific personal care services must be prescribed by a physician in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State or designee. The services are provided by an individual who is qualified to provide such services and who is not a member of the individuals immediate family. The services may be furnished in a home or other location.

Personal Care tasks include:

1) Basic personal hygiene - providing or assisting with:

   a) bathing (tub, bed bath, shower);
   b) shampoo, hair grooming;
   c) shaving;
   d) nail care - hands;
   e) nail care - feet (only with RN approval);
   f) foot care;
   g) dressing;
   h) skin care - application of emollients if approved by physician, repositioning (see 5b).

2) Bowel and bladder care:

   a) assisting on and off toilet, commode or bedpan, diapering;
   b) external cleansing of perineal area;
   c) external cleansing of Foley catheter - after demonstrating technique to RN;
   d) emptying catheter drainage bag - after demonstrating technique to RN;
   e) changing colostomy or ileostomy bag for individual with stabilized condition;
   f) encouraging adequate fluid intake;
   g) maintenance bowel care, with RN approval.

3) Assisting client to take medications:

   a) open and properly reseal medication containers if client unable to do so;
   b) observe to assure client taking medication as ordered by physician;
   c) remind appropriate person when prescription refill needed;
   d) administration of stabilized, maintenance medication(s).

4) Assist oxygen:

   a) maintain clean equipment;
   b) assist with maintaining adequate supply.

LIMITATIONS ON SERVICES

24f. Personal Care Services (42 CFR 440.170(f)) (Cont.)

5) Assist with mobility, transfers and comfort:

   a) assist with ambulation with or without aids;
   b) assure repositioning every two hours or more often for bedridden or wheelchair-using individuals clients;
   c) encourage active range-of-motion exercises when indicated;
   d) assist with passive range-of-motion exercise if ordered by physician and RN has observed and approved technique;
   e) assist with transfers with or without mechanical devices.

6) Nutrition:

   a) prepare nutritional meals;
   b) plan and prepare special diets as ordered by physician;
   c) assure adequate fluid intake;
   d) feed if necessary.

7) Care of confused, mentally or physically disabled client:

   a) assure maximum safety of client;
   b) provide or assist with approved activities.

8) First aid and handling of emergencies:

   a) discussed and approved at time of first visit;
   b) maintain and prioritize emergency notification system.

9) Perform housekeeping tasks necessary to maintain the client in a healthy and safe environment.

10) Arrange and assist client to and from necessary appointments-

11) Observation of client status and reporting of any significant changes to the appropriate case manager or other person as designated by the care plan.

12) Tasks delegated by a nurse.

Personal care services are provided subject to rules and procedures set forth in Oregon Administrative Rules.

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

CASE MANAGEMENT SERVICES

A. Target Group: See Attachment.

B. Areas of State in which services will be provided:

/X/ 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:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 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.

D. Definition of Services: See Attachment.

E. Qualification of Providers: See Attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

F. The State assures that the provision of case management services not restrict an Individual/s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. 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.

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)

Targeted case management services are provided to eligible Medicaid recipients who have a developmental disability. Developmental disability is a disability attributable to mental retardation, autism, cerebral palsy, epilepsy, or other neurological handicapping condition which requires training similar to that required by persons with mental retardation, and the disability:

(a) Originates before the person attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18;

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the individual to function in society.

Targeted case management services are provided to all persons with a developmental disability or those who are waiting for a determination of eligibility who apply for service.

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

The purpose of case management is to access, coordinate and assure the delivery of services and supports required by individuals with developmental disabilities. Case management will assist eligible individuals under the plan in gaining access to needed medical, social, educational and other services. Services include: (1) determination of appropriateness and need for developmental disabilities services; (2) evaluation of individual needs; (3) re-evaluation of individual needs; (4) development of an individual service plan; (5) monitoring of the individual service plan; (6) assisting the individual in obtaining needed services; (7) assisting the individual in accessing crisis services; (8) coordination of protective services; investigation and documentation of complaints; (9) coordination of services with other agencies who are involved with the individual (i.e., Adult and Family Services, Children's Services Division, Vocational Rehabilitation Division, Senior Services Division, Social Security Administration, Veteran's Administration, Department of Education, et cetera).

Targeted case management services will not duplicate any other Medicaid service provided under the State plan or under a waiver. Medicaid will be the payor of last resort.

Payment will not be made for services for which another payor is liable, or for services for which no payment liability is incurred. Separate payment will not be made for case management type services which are an integral and inseparable part of another Medicaid service.

Referral for Medicaid services will be considered a component of case management services, but the actual provision of the service will not constitute case management. Referral and arrangements for treatment will be considered a case management service, but the actual treatment will not.

Case management-type activities necessary for the proper and efficient administration of the State plan will not be considered components of case management services. These activities are as follows: (1) Medicaid pre-admission screening, (2) prior authorization for Medicaid services, (3) institutional discharge planning, (4) client outreach.

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

Section 1915(g)(1) of the Act was amended by OBRA 87 to allow states to limit case managers who may provide case management services for eligible individuals with developmental disabilities. The purpose was to make certain that case managers for such individuals are capable of ensuring that the individuals receive the full range of services they need. Oregon has developed qualification criteria which will limit case managers to those who meet the standards described below.

Case managers employed after July 1, 1989 will have a minimum of an undergraduate degree in a human services field, and one year experience in the field of developmental disabilities. The state may-grant waivers for individuals with five or more years work experience and training in the field of developmental disabilities.

As of July 1, 1989, when newly employed, case managers shall participate in an initial basic training sequence. The training materials will be provided by the State and the provision of training may be conducted by the Mental Health Division or community Mental Health Program depending on available resources. For counties who do not have local training resources, the Mental Health Division will offer basic inservice training. This training will not be a substitute for the normal procedural orientation that would occur for a new employee during the first 90 days of a case manager's employment.

Each case manager shall be required to participate in a minimum of 20 hours per year of advanced training in the area of developmental disabilities. The Community Mental Health Program will show, in their annual plan, how they anticipate fulfilling this requirement.

The Community Mental Health Program will document attendance at required training in each employee's personnel file.

Definitions and Explanation

A case manager is an employee of a Community Mental Health Program or other agency contracted by the County or Mental Health Division and designated to plan, coordinate, and monitor services and advocate for persons with developmental disabilities.

A Community Mental Health Program is an organization of services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the State.

A local mental health authority must be the county court or board of commissioners of one or more counties who operate a community mental health program, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation.

Case management services will be provided statewide by local community mental health authorities, or public or private corporations under contract with the Oregon Mental Health Division.

Additional Assurances (Section F of Supplement 1, State Plan Preprint)

Any person or entity meeting State standards for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so. Case management services will not be used to restrict the access of the individual to other services available under the State plan.

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.

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)

Targeted case management services are provided to all Medicaid eligible recipients under age 21 and who are currently residing **in an in-home setting**, a foster home, group home, residential care facility, or independent living situation ~~the financially supported through~~ **under the responsibility of** the State Office for Services to Children and Families (SOSCF) ~~and~~ **or the** Oregon Youth Authority (OYA).

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

Case management services are those services which include:

1. Assessment
   After **the need for targeted case management services has been determined**, ~~client had been placed in substitute care and is determined in need of targeted case management services,~~ the case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the case manager makes preliminary decisions about needed medical, social, educational, or other services and level of agency intervention.

2. Case Planning
   The case manager develops a case plan, in conjunction with the client and family, to identify the goals and objectives which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the case manager, the family and client. This activity will include accessing medical, social, educational, and other services to meet the client's needs.

3. Case Plan Implementation
   The case manager will link the client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The case manager will facilitate implementation of agreed-upon services through assisting the client and family to access them and through assuring the clients and providers fully understand how these services support the agreed-upon case plan.

TN No. 99-04
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D. Case Plan Coordination
After these linkages have been completed, the case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the client and family. Coordination activities include, but are not limited to, personal, mail and telephone contacts with providers, and well as meetings with the client and family to assure that services are being provided and used as agreed.

D. Case Plan Reassessment
The case manager will determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. This may include assisting clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, but are not limited to, staffings and mail, personal, and telephone contacts with involved parties.

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

Provider Organizations

Case management provider organizations must be certified as meeting the following criteria:

D. A minimum of three years experience of successful work with children and families, involving a demonstrated capacity to provide all core elements of case management, including Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment.

D. 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.

D. A minimum of three years experience working with the target population.

D. Administrative capacity to ensure quality of services in

accordance with state and federal requirements.

E. Financial management system which provides documentation of services and costs.

F. Capacity to document and maintain individual case records in accordance with state and federal requirements.

G. Demonstrated commitment to assure a referral consistent with section 1902a(23), freedom of choice of providers.

H. A minimum of three years experience demonstrating capacity to meet the case management service needs of the target population.

I. Qualifications of Case Managers

1. Completion of training in case management curriculum approved by the office of Medical Assistance Programs.

2. Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders.

3. 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.

4. Ability to work with court systems, to learn state and federal rules, laws and guidelines relating to child welfare, and to gain knowledge about community resources.

Additional Assurance (Section G of Supplement 1, State Plan Preprint)

Payments for targeted case management will be made through the MMIS system. The state Medicaid agency assures that no case management administrative activities will be billed as targeted case management services. SOSCF will utilize the Random Moment Tune Sampling process to allocate case management administrative activities as separate costs, distinct from targeted case management services. Other providers of targeted case management must also provide assurances that they will not bill other federal programs. Payments for targeted case management will be made through the MMIS system to all qualified provider organizations. Use of this system assures that duplicate payments will not be made to more than one provider for targeted case management services provided to the same client.

TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID HIGH RISK INFANTS AND CHILDREN

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

Targeted case management services will be provided to all Medicaid eligible infants and preschoolers through three years of age who are at risk of poor health outcome.

RISK CRITERIA

MEDICAL RISK FACTORS

Drug exposed infant
Infant HIV Positive
Maternal PKU or HIV Positive
Intracranial Hemorrhage (excludes Very High Risk Factor B16)
Seizures (excludes VHR Factor B18)
Perinatal asphyxia
Small for gestational age
Birth weight 1500 grams or less)
Mechanical ventilation for 72 hours or more
Neonatal hyperbilirubinemia
Congenital infection (TORCH)
CNS infection (e.g., meningitis)
Head trauma or near drowning
Failure to thrive
Chronic illness
Suspect vision impairment
Vision impairment
Family history of childhood onset Hearing Loss

SOCIAL RISK FACTORS

Maternal age 16 years or less
Parents with disabilities or limited resources
Parental alcohol or substance abuse
At-risk care giver
Concern of parent/provider
Other

DEVELOPMENTAL RISK FACTORS

Borderline developmental delay
Other

ESTABLISHED RISK CATEGORIES

Heart disease
Chronic orthopedic disorders
Neuromotor disorders including cerebral palsy & brachia nerve palsy
Cleft lip and palate & other congenital defects of the head and face
Genetic disorders including fetal alcohol syndrome
Multiple minor physical anomalies
Metabolic disorders
Spina bifida
Hydrocephalus or persistent ventriculomegaly
Microcephaly & other congenital defects of the CNS
Hemophilia
Organic speech disorders (dysarthria/dyspraxia)
Suspect hearing or hearing loss
Burns
Acquired spinal cord injury etc., paraplegia or quadriplegia

VERY HIGH RISK MEDICAL FACTORS

Intraventricular hemorrhage
(grade III, IV) or cystic
Periventricular leukomalacia
(PVL) or chronic subdurals
Perinatal asphyxia and
seizures
Oromotor dysfunction requiring
specialized feeding program
(include infants with
gastrostomies)
Chronic lung disease on oxygen
(includes infants with
tracheostomies)
Suspect neuromuscular disorder
including abnormal
neuromotor exam at NICU discharge

Areas of State in Which Services Will Be Provided (Section B of Supplement 1, State Plan Preprint)

Entire State

Only in the following geographic areas (authority of S1915(g)(1) of the Act is invoked to provide services less than statewide):

Comparability of Services (Section C of Supplement 1, State Plan Preprint)

Services are provided in accordance with S1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of S1915(g)(1) of the Act is invoked to provide services without regard to the requirements of S1902(a)(10)(B).

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

Required Case Management Activities

Case Management services must include:

1. Screening - Examination by single test or procedure in order to detect an unrecognized problem. Screening is not designed to diagnose the problem, but to sort the target population into two groups: those at risk for an particular health problem and those not at risk.

   The case manager will screen the infant/toddler. The Medicaid agency has chosen to use standardized screening tools or to follow specific protocols approved by the Title V Agency.

2. Assessment - The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas. Data sources include client interview, existing available records, and needs assessment.

3. Intervention

   a. Linkage - establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to clients.

   b. Planning - Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion.

   c. Implementation - Putting the plan into action and monitoring its status.

   d. Support - Support is provided to assist the family to reach the goals of the plan; especially if resources are inadequate or the service delivery system is non-responsive.

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

Case management 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
   f. Tracking and follow-up to assure that no client is lost to the case management system during the rapid developmental period of the first 47 months of life.

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.

Manager Qualifications

The case manager must be a licensed registered nurse with one year of experience in community health, public health, child health nursing, or be a registered nurse or certified home visitor under the supervision of the above.

The case manager must work under the policies, procedures, and protocols of the State Title V MCH Program.

<u>Freedom of Choice</u> (Section F of Supplement 1, State Plan Preprint)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of S1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

   (a) Approved S1915(b) waivers will apply to free choice of the providers of other medical care under the plan.

<u>Payment</u> (Section G of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

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

Targeted case management services are provided to all Medicaid eligible recipients with (1) symptomatic HIV disease and (2) one or more risk factors which result in an inability to remain in a home environment without ongoing management of support services. Such risk factors are:

- Advanced HIV-related dementia-confusion, severe memory loss, aggressive behavior
- Need for assistance, to ambulate and/or transfer between bed and chair
- Suicidal ideation with plan for action
- Need for assistance with activities of daily living based on severe fatigue and weakness
- Care providers/family members overwhelmed by needs of the person with HIV disease
- Uncontrolled pain
- Loss of ability to manage medically prescribed care at home (medication, skin care, IVs)
- Significant weight loss associated with frequent diarrhea, nausea, vomiting and/or anorexia
- Inability to maintain adequate nutrition
- Decreased mobility-potential for falls
- Presence of substance abuse in conjunction with advanced HIV disease
- Presence of chronic mental illness in conjunction with advanced HIV disease
- Complex family situations (e.g., both spouses or partners infected)
- Families with children affected by HIV (parent or child infected)
- Homelessness or inadequate housing/heat/sanitation
- Inability to manage household activities due to advanced HIV disease

Areas of State in which services will be provided (Section B of Supplement 1, State Plan Preprint)

Only in the following geographic areas (authority of 1915(g)(1) of the Act is invoked to provide services less than statewide):

Services will be provided in Multnomah County.

Comparability of Services (Section C of Supplement 1, State Plan Preprint)

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(i) 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 (Section D of Supplement 1, State Plan Preprint)

Case management services include:

1. Assessment: the systematic ongoing collection of data to determine current status and identify client's physical, psychosocial, and educational needs. An HIV nursing assessment tool will measure ability of the client to manage care at home including pain control medication management, nutritional needs, personal care needs, home safety assessment, coping with symptoms and disease process, as well as education and service needs that might enhance the client's ability to maintain an independent lifestyle as long as possible. Data sources will include client and support person interviews, information from the referral source, communication with health care team members, and existing available records.

2. Comprehensive care/services plan development: identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated integrated fashion. Emphasis is placed on client independence and client participation in planning of his/her own care. Natural support systems include family members, partners, and friends.

3. Intervention/implementation: putting the plan into action and monitoring its status. When possible intervention is provided in the home where retention of information is improved, the cost of clinic space is saved, and support persons can be included. Case management will not provide direct interventions but will identify, refer to, and arrange for needed support services such as:

   - Medication management systems, including safe levels of pain control
   - Nutritional support programs (teaching, meals on wheels, arranging for a volunteer)
   - Care plans for the coordination of volunteers
   - Disease specific education of clients and care givers
   - Care giver respite
   - Child care
   - Grief and loss counseling
   - Personal care decisions
   - Benefits eligibility
   - Stress reduction
   - Mental health assessments
   - Substance abuse treatment
   - Spiritual counseling
   - Emotional support to clients, partners, and family members
   - Facilitating early hospital discharge by assuring that support systems are in place prior to patient discharge
   - Coordination of client care
   - Coordination of home health agency and hospice nursing services

4. Coordination/linking of services: establishing and maintaining a referral process with pertinent individuals and agencies to avoid duplication of services to clients, to assist clients in accessing resources, and to solicit referrals from the community into the managed care system. Support and coordination is provided to assist the client and service providers to reach the goals of the plan; especially if resources are inadequate or service delivery system is non-responsive.

5. Evaluation: each visit will include a reassessment of the client's status and needs, review and update of the care plan, appropriate action and referral, and accurate record keeping.

Provider Qualifications (Section E of Supplement 1, State Plan Preprint)

Case management 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 nursing 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 ensure 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.

Case Manager Qualifications

The case managers must be licensed registered nurses with a minimum of one year of experience in public health or home health and-HIV disease or be a registered nurse working under the supervision of the above.

The case manager must work under the guidelines of the qualified organization.

F. Freedom of Choice (Section F of Supplement 1, State Plan Preprint)

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of S1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

    (a) Approved S1915(b) waivers will apply to free choice of the providers of other medical care under the plan.

Payment (Section G of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID ELIGIBLE SUBSTANCE ABUSING PREGNANT WOMEN AND WOMEN WITH YOUNG CHILDREN

Target Group (Section A of Supplement 1, State Plan Preprint)
Targeted case management services will be provided to Medicaid eligible women who: 1) are either pregnant or have children under the age of five; and 2) are in need of treatment for the abuse of alcohol and other drugs.

Areas of State in which Services will be Provided (Section B of Supplement 1, State Plan Preprint)

Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

Six county area to include: Polk, Yamhill, Linn, Benton, Jackson and Marion Counties.

Comparability of Services (Section C of Supplement 1, State Plan Preprint)

Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

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

Required Case Management Activities

Case Management Services are those services which include:

1. Screening and Assessment - The case manager gathers information to assess the client's need for various services, foremost being treatment for alcohol and drug abuse-addiction. Information will be gathered from the criminal justice system, the Housing authority, and other sources as appropriate. A uniform assessment tool will be used for screening clients and identifying needed services.
2. Case Plan Development - The case manager brings together a treatment team that will consist of the case manager, alcohol and drug treatment provider, criminal justice system representatives, prenatal provider, and others instrumental in the client's life.

The treatment team will develop a case plan encompassing such components as alcohol and drug treatment, medical care, housing, education, child , vocational, and mental health services. Goals and objectives will be written, and resources will be identified to meet the client's needs in a coordinated, integrated fashion. The case plan will be refined in periodic meetings of the treatment team (case conferences) as treatment progresses

3. Intervention/Implementation - The case manager will link the client with appropriate agencies and services identified in the case plan through calling or visiting these resources. The case manager will facilitate implementation of agreed-upon services through assisting the client in accessing the services and through assuring that the clients and providers fully understand how these services support the agreed-upon case plan.

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

Provider Qualifications

Case management 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 service activities described above:

2. Understanding and knowledge of local and state resources/services which may be needed and available to the target population.

3. Demonstrated case management experience in coordinating and linking the needed community resources with the client and their families as required by the target population.

4. Demonstrated experience in working with the target population.

5. Sufficient level of staffing to meet the case management service needs of the target population.

6. An administrative capacity to monitor and ensure quality of services in accordance with State and Federal requirements.

7. A financial management capacity and system sufficient to provide documentation of service and costs.

8. Capacity to document and maintain individual case records in accordance with State and Federal requirements.

9. Demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program.

10. Ability to link with the Title V statewide Maternal and Child Health Data System or provide another computerized tracking and monitoring system to assure adequate follow-up and to avoid duplication.

Case Manager Qualifications

The case manager must be a registered nurse or a MSW with one year of experience coordinating human services, or a registered nurse or MSW without this experience who works under supervision of the above.

In addition, the case manager must work in compliance with the policies, procedures, and protocols approved by State Title V MCH Program to assure that minimum standards of care occur (e.g., nutrition assessments and services and sufficient office visits for good pregnancy outcomes).

Within the first year of employment, the case manager will have to successfully complete specialized training in case management of the target population. This training will be provided by the Office of Alcohol and Drug Abuse Programs and the Health Division.

Freedom of Choice (Section F of Supplement 1, State Plan Preprint)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of X1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

   (a) Approved S1915(b) waivers will apply to free choice of the providers of other medical care under the plan.

Payment (Section G of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Section 1915(g) of the Social Security Act is Authority for this Amendment.

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

The target group consists of 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.

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

Tribal Targeted Case management services are those services, which include:

(1) Assessment

After the need for tribal targeted case management services has been determined, the tribal case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary decisions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

(2) Case Planning
The tribal case manager develops a case plan, in conjunction with the client and family (where applicable), to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the tribal case manager, the family and client. This activity will include accessing medical, social, educational, and other services to meet the clients' needs.

(3) Case Plan Implementation
The tribal case manager will link the client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The tribal case manager will facilitate implementation of agreed-upon services through assisting the client and family to access them and through assuring the clients and providers fully understand how these services support the agreed-upon case plan.

(4) Case Plan Coordination
After these linkages have been completed, the tribal case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the client and family. Coordination activities include, personal, mail and telephone contacts with provider s and others identified by the case plan, and well as meetings with the client and family to assure that services are being provided and used as agreed

5) Case Plan Reassessment
In conjunction with the individual, the tribal case manager will determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. Reassessment will also determine whether the case plan itself requires revision. This may include assisting clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, staffing and mail, personal, and telephone contacts with involved parties.

Provider Organizations

A Tribal case management provider must be an organization certified as meeting the following criteria:

A. 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.

B. 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.

C. Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements.

D. Maintain a sufficient number of case managers to ensure access to targeted case management services.

Qualifications of Case Managers within Provider Organizations:

- 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 (Section F of Supplement 1, State Plan Preprint)

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.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical Care under the plan.

(a) When an individual is served through an approved Section 1915(b) waiver, the terms of that waiver will govern freedom of choice of the providers of other medical care under the plan.

Payment (Section *G* of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. 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.

TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID ELIGIBLE CLIENTS SERVED BY THE LOCAL MENTAL HEALTH AUTHORITY

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

Targeted case management services will be provided to Medicaid eligible clients seeking or obtaining mental health or substance abuse treatment from participating Local Mental Health Authorities.

Areas of State in Which Services Will Be Provided (Section B of Supplement 1, State Plan Preprint)

Entire State

X Only in the following geographic areas (authority of S1915(g)(1) of the Act is invoked to provide services less than statewide): All areas of the state where there is a participating Local Mental Health Authority.

Comparability of Services (Section C of Supplement 1, State Plan Preprint)

Services are provided in accordance with S1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration and scope. Authority of S1915(g)(1) of the Act is invoked to provide services without regard to the requirements of S1902(a)(10)(B).

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

Case Management services include in-person, electronic, telephone and mail exchanges to accomplish the following:

1. Screening and Assessment
The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, social, behavioral, emotional, and mobility areas. Data sources include client interview, existing available records, and needs assessment.

2. Case Plan Development
The case manager develops a case plan, in conjunction with the client and family, as appropriate, to identify goals, objectives and issues identified through the assessment process. Case planning includes determining activities to be completed by the case manager, client and family. These activities include, but are not limited to, accessing appropriate health and mental health, social, educational, vocational, transportation services, etc. to meet the clients needs.

3. Intervention
   a. Linkage - establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to clients.
   b. Planning - Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion.
   c. Implementation - Putting the plan into action and monitoring its status.
   d. Support - Support is provided to assist the family to reach the goals of the plan; especially if resources are inadequate or the service delivery system is non-responsive.

4. Case Plan Reassessment
The case manager determines whether or not the linked services continue to meet the clients needs, and if not, adjustments are made and new or additional referrals made to adequately meet the defined client needs. Reassessment may include staffings and electronic or mail exchange, personal and telephone contacts with involved parties.

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

Case management provider organizations must be Local Mental Health Authorities that meet 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 ensure 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.

Case Manager Qualifications

The case manager must be a Qualified Mental Health Professional or Qualified Mental Health Associate as defined in the Oregon State Plan under Title XIX, Attachment 3.1, section 13.d. Transmittal #96-07; or

Certified Alcohol and Drug Counselor as defined in Oregon Revised Statutue, Chapter 415: or

Persons employed by or working under the direction of the Local Mental Health Authority that have successfully completed a basic case management training course approved by The Department of Human Services.

Freedom of Choice (Section F of Supplement 1, State Plan Preprint)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of S1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

   (a) Approved S1915(b) waivers will apply to free choice of the providers of other medical care under the plan.

Payment (Section G of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payment Methodology for Targeted Case Management

Reimbursement for targeted case management for Medicaid eligible persons served by Local Mental Health Authorities is fee for service based on 15 minute service increments. Payments are based on a state wide fee schedule. The fee schedule will be two tiered based upon the difference in case manager qualifications.

CASE MANAGEMENT SERVICES

Section 1915(g) of the Social Security Act is Authority for this Amendment.

A. Target Group

Preschool children with disabilities, birth until eligibility for public school who are either eligible for Early Intervention services under OAR 581-015-0946(3); or Early Childhood Special Education services under OAR 581-015-0943 (4), (EI/ECSE).

B. Areas of State in which services will be provided:

__X__ 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.)

C. Comparability of Services

___ Services are provided in accordance with section 1902 (a)(10)(B) of the Act.
__X__ Services are not comparable in amount, duration and scope. Authority of section 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.

D. Definition of Services

Case management is provided to children in the target group to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services. The case manager is responsible for assisting the child and family in gaining access to and coordinating all services across agency lines and serving as the single point of contact in helping child and family obtain the services and assistance they need. Case management may be delivered in person, electronically, or by telephone for the purpose of enabling the child and family to gain access to and obtain the needed services.

Case management services include:

Intake and Needs Assessment

The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, social, behavioral, emotional, and mobility areas. Data sources include family interview, existing available records, and needs assessment.

Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individualized Family Service Plan (IFSP)

The case manager (service coordinator) develops a targeted case management plan coordinated with the IFSP, in conjunction with the family and other IFSP team members to identify goals, objectives and issues identified through the targeted case management assessment process. Targeted case management case planning includes determining activities to be completed by the case manager, in support of the child and family. These activities include accessing appropriate health and mental health, social, educational, vocational, and transportation services to meet the child's needs.

Service Coordination and Monitoring

a. Linkages - establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to the child and family.

b. Planning - Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion with the family and other IFSP team members.

c. Implementation - Putting the targeted case management plan into action and monitoring its status.

d. Support - Support is provided to assist the family to reach the goals of the plan; especially if resources are inadequate or the service delivery system is non-responsive.

Reassessment and Transitioning Planning

The case manager (service coordinator), in consultation with the family and other IFSP team members, determines whether or not the linked services continue to meet the child and family's needs, and if not, adjustments are made and new or additional referrals are made to adequately meet the defined child and family needs.

These services:

a) Assist families of eligible children in gaining access to EI/ECSE services and other medical or social services identified in the targeted case management plan ;
b) Permit coordinating of EI/ECSE services and other medical or social services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;
c) Assist families in identifying available medical and social service providers;
d) Permit coordination and monitoring the delivery of available medical or social services;
e) Inform families of the availability of medical/social services;
f) Maintain a record of targeted case management activities in each child's record.

E. Qualification of Case Managers (Service Coordinators)

Case managers (service coordinators) must be employees of the EI/ECSE contracting or subcontracting agency and meet the personnel standards requirements in OAR 581-015-1100. Service Coordinators must have demonstrated knowledge and understanding about:

a) The Oregon EI/ECSE program;
b) The Individuals with Disabilities Education Improvement Act;
c) The nature and scope of services available under the Oregon EI/ECSE program, the system of payments for services and other pertinent information.

F. Qualifications of Provider Organizations

Provider organizations must be contractors or subcontractors with the Oregon Department of Education in the provision of EI/ECSE services.

G. The state assures that the provisions of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a)(23) of the Act.

1. Eligible consumers will have free choice of the providers of case management services.
2. Eligible consumers will have free choice of the providers of other medical care under this plan.

H. Payment for case management services under the plan does not duplicate payments made to public or private entities under other program authorities for this same purpose.

Payment Methodology for EI/ECSE Targeted Case Management

Payment for Targeted Case Management will be based on a monthly encounter rate. The payment methodology is referenced in Section 4.19 of the State Medicaid Plan. The reimbursement will be at cost based on the following:

Rate Computation Methodology
The rate for reimbursement of the case management services is computed as follows:

Compute the	Annual Case Manager salary and fringe benefits
Plus	Other operating cost including travel, supplies, telephone, and occupancy cost
Plus	Direct supervisory cost
Plus	Average indirect administrative cost of provider organization
Equals	TOTAL ANNUAL COST PER CASE MANAGER
Divided by	12
Equals	MONTHLY COST PER CASE MANAGER
Divided by	Number of children to be served during month
Equals	TOTAL MONTHLY COST PER CHILD

The total cost per case manager is the sum of the case manager's salary, direct supervisory costs, indirect administrative costs of the provider organization and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average monthly cost per case manager. Dividing the monthly cost per case manager by the number of children to be served during the month results in the total monthly costs per child. This is the encounter rate to be used for the monthly billing whenever a Medicaid eligible client receives a TCM service during that month.

State of Oregon

Name and address of State Administering Agency, if different from the State Medicaid Agency.

____

____

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:

(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.)

In accordance with Appendix C, page 2, item b. of Oregon's Home and Community Based Waiver (#0185.90 R2), the applicable group is the group of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are those individuals with a special income level equal to 300% of the SSI Federal benefit (FBR).

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(s).

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) _____SSI
         (b) _____Medically Needy
         (c) _____The special income level for the institutionalized
         (d) _____Percent of the Federal Poverty Level: ______%
         (e) _X_ Other (specify): SSI + state supplement________

      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.

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

(C.) Family (check one):
1._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. _____ 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.

(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.

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. _____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:

____

____

____

II. Rates and Payments

A. The State assures HCFA 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 HCFA Regional Office for prior approval.

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.

State of Oregon
PACE Rate Methodology and Upper Payment Limit Calculation

The following information is organized and is consistent with the format of the document titled: PACE: Upper Payment Limit Development and Capitation Rates January 1, 2006-December 31, 2006 submitted by Price Waterhouse Coopers LLP November 2005. The Upper Payment Limits calculated for the PACE program were 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 Multnomah County who are age 55 and older who are Medicaid eligible (which excludes SLMB and QMB-only who are not Medicaid eligible and Medically Needy individuals) and are long term care eligible in service priority categories Levels 1- 13.

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.
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.
8. Smoothing techniques were applied to the unadjusted UPLs to improve predictability. The smoothing process was cost-neutral in the aggregate.

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 by demographic group based on the distribution of costs for nursing facility and Home and Community Based Care (HCBC) services. (P&I)

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 Multnomah County was created. PACE participants were excluded from this population.
2. This eligibility information was matched against the nursing facility and HCBC claims data to create the claims experience for the Multnomah County PACE-eligible population.
3. Claim data was summarized to obtain information on total amounts for the data period by service category and demographic grouping.
4. Non-MMIS costs were added. Since this data was available only on a statewide basis, the costs were converted to a PMPM amount to allow for their inclusion in the UPL. An assumption was made that Multnomah County costs in these areas are comparable to the statewide population. These costs were allocated to the demographic groupings proportionately to the total of the nursing home and HCBC costs.
5. The PACE eligibility information was used to develop member months of eligibility. These figures were then used as the denominator in the calculation of per capita costs.
6. An adjustment was made for the relative expected cost of PACE-eligibles with survival priority scores of 1-13 relative to the total PACE-eligible population.
7. Trend rates were developed for various service categories.
8. 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. The UPLs are kept separate and 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.

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

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.

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)
1927(d)(2) and 1935(d)(2)	1.	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.
	_X	The following excluded drugs are covered:
	_X_	(a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
	_X_	(b) agents when used to promote fertility (see specific drug categories below)
	_X_	(c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
	_X_	(d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)
	_X_	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
	_X_	(f) nonprescription drugs (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)	
1927(d)(2) and 1935(d)(2)	_X_	(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)
	_X_	(h) barbiturates (see specific drug categories below)
	_X_	(i) benzodiazepines (see specific drug categories below)

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.

__ No excluded drugs are covered.

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SEPTEMBER 1986

Transmittal #91-25
Attachment 3.1-B
Page 1

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-

State/Territory: OREGON

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

c. Prosthetic devices.

/ / Provided / / No limitation / / With limitations*

d. Eyeglasses.

/ / Provided / / No limitation / / With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/ / Provided / / No limitation / / With limitations*

b. Screening services.

/ / Provided / / No limitation / / With limitations*

c. Preventive services.

/ / Provided / / No limitation / / With limitations*

d. Rehabilitative services.

/ / Provided / / No limitation / / With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided / / No limitation / / With limitations*

b. Skilled nursing facility services.

/ / Provided / / No limitation / / With limitations*

*Description provided on Attachment.

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.

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 OF OREGON

Methods of Providing Transportation

Transportation including expense for transportation and other related travel expenses necessary to secure medical examinations and or treatment when determined by agency to be necessary in the individual case. "Travel expenses" are defined to include the cost of transportation for the individual by ambulance, taxi cab, common carrier, or other appropriate means; the cost of outside meals and lodging in route to, while receiving medical care, and returning from a medical resource; and the cost of an attendant to accompany if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging, and salary of the attendant, except that no salary shall be paid a member of the patient's family.

Note: Change in att. Number required by AT-82-30.
Change in title authorized by AFS letter to Region X dated 4-26-83.

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.

Transmittal #04-14

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 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 OF OREGON

The standards specified in paragraphs (a) and (b) on page 42 of the Plan are:

For general hospitals, psychiatric hospitals, skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded contained in Chapter 441, Oregon Revised Statutes, and rules and regulations applicable to each type of facility.

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

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

outdoor toilets, garage, shed, spring or well house, and barns or other buildings that house animals used for the individual's consumption. An individual's home, in most instances, is located within the state of Oregon. However, an individual's home may be located outside the state of Oregon.

o **EQUITY INTEREST IN THE HOME** means the value of an individual's home less the unpaid principal balance of any loans or other liens or encumbrance affecting the individual's home.

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 XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

   Each Estate Administrator has the authority to determine if an estate will be pursued for collection based on the likelihood of recovering the value of the claim as it compares to the cost of collection.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

   Upon the death of a recipient of assistance subject to recovery, and provided the recipient has no surviving spouse, minor child, or a child who is blind or disabled according to SSI criteria, and provided there is no real property or titled personal property which would require the filing of an estate proceeding, (small estate or probate), the Department may claim any funds up to $25,000 which belonged to the recipient and which are on deposit with a bank (ORS 708.430), savings and loan (ORS 722.262), or credit union (ORS 723.463).

   When the Estate Administration team receives a report on deceased persons meeting the conditions above, the team sends the banking letter, an affidavit, and indemnity agreement to the identified financial institution claiming the account of the decedent. Individuals who contact us and notify us of creditors who have a priority before the State are advised to send the billings to the Estate Administrator and the bill is satisfied to the extent that the assets are available, e.g., funeral expenses.

   A small estate may be filed when an individual dies leaving an estate with a fair market value of $140,000.00 or less; not more than $50,000.00 attributable to personal property and not more than $90,000.00 attributable to real property. An affidavit may not be filed until 30 days after the death of the decedent. A probate proceeding can be filed at any time for an estate of any dollar value or when the value of the estate exceeds the small estate limitations.

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	$2 for each generic prescription that is filled or refilled. $3 for each brand prescription that is filled or refilled. • The co-payment is based on the average payment for drug for CY 2001.
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

State: **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 and supplies: The POS System will identify and exclude family planning drugs such as birth control pills, and supplies from cost share.

HMO Enrollees: All individuals identified to the provider through the POS system, are exempt from co-payments for those services which are covered by the plan.

IHS/Tribal Health Facilities under Section 638: Clients who receive services through federally recognized IHS/Tribal Health Facilities (IHS) under Section 638. The MMIS & POS will identify & exclude co-payments for individuals utilizing services through IHS/Tribal Health Facilities under Section 638.

Mail Order Prescription: The POS system will identify and exclude prescription drugs dispensed through the mail order drug program.

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			Amount of Basis for Determination
	Deduct.	Coins.	Copay.	

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August 1991

Transmittal #91-25
Attachment 4.18-D
Page 1
OMB No. 0938-

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)

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TN # 96-15 DATE APPROVED 2/6/97
SUPERSEDES TN # 91-18 EFFECTIVE DATE 10/1/96

METHODS AND STANDARDS FOR PAYMENT OF INPATIENT MEDICAL HOSPITAL SERVICES

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 OMAP. Reimbursement is made according to the terms of a contract between OMAP 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
P&I terms of an agreement between the Office of Mental Health and Addition Services (OMHAS) 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.

(5) 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 March 1, 2004 has been established as 80% of the published 2004 Medicare Unit Value (Labor and Non-Labor).

P&I The Unit Value plus the Capital amount multiplied by the claim assigned DRG relative weight is the hospital's Operational Payment.

P&I 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 Department, in accordance with 42 CFR 447.205, will make public notice of changes whenever a Unit Value adjustment is made under the provision of this subsection. Public notice of changes will be made in accordance with 42 CFR 447.205 whenever a unit value adjustment is made under the provisions 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.

Transmittal #03-20

- 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. The Office of Medical Assistance Programs (OMAP) uses the Medicare definition and calculation of capital costs. As of March 1, 2004, OMAP will use Medicare 2004 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 fiscal year 2004.

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.

(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.

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: 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 OMAP records for the same cost reporting period.

Information on total paid Medicaid days is taken from Office of Medical Assistance Programs (OMAP) reports of paid claims for the same fiscal period as the Medicare Cost Report.

b. Criteria 2: A low Income Utilization Rate exceeding 25

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 a 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 impatient charges are reduced due to contractual allowances and discounts to other health insurance or third party payers, such as HMO'S, Medicare, Medicaid, etc.

The information used to calculate the Low Income Utilization rate is taken from the following sources:

- The most recent Medicare Cost Reports.
- OMAP 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 OMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

OMAP determines within 30 days of receipt of all required information if a hospital is eligible under the Low Income Utilization rate criteria.

c. Other Disproportionate Share Eligibility Requirements

To receive DSH payments under Criteria I and Criteria 2, 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 21, 1987. No hospital may qualify for DSH payments, unless the hospital has, at a minimum, a Medicaid utilization rate of one percent. 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.

Information on total inpatient days is taken from the most recent Medicare Cost Report.

Information on total paid Medicaid days is taken from OMAP reports of paid claims for the same fiscal period as the Medicare Cost Report.

d. Disproportionate Share Payment Calculations

Eligibility Under Criteria 1

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 quarter multiplied by a percentage of the hospital-specific Unit Value in effect on February 29, 2004. 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.

Eligibility under Criteria 2

For hospitals eligible under Criteria 2 (Low Income Utilization Rate), the quarterly DSH payment is the sum of DRG weights for claims paid by OMAP 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 February 29, 2004 unit value. The Unit Value used for eligible Type A and Type B hospitals is the current Unit Value set at the 50th percentile.

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 OMAP 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.

e. Additional 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 adjustment will be determined using the following sources:

The most recent Medicare Cost Reports.

OMAP'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.

"P&I" Any other information which OMAP, working in conjunction with representatives of qualifying Oregon hospitals, determines necessary to establish cost.

"P&I" 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
Base year (the most recent completed fiscal year for the qualifying hospital) Medicaid charges will 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 base year to arrive at Medicaid uncompensated care costs. These costs are then adjusted to the payment year using the Consumer Price Index – Hospital and Hospital Related Services.

1. Uncompensated Care Costs for Medicaid Clients

2. Uncompensated Care Costs for Indigent and Uninsured Patients
"P&I" The average of the three most recent base years' uncompensated care costs adjusted by the Consumer Price Index – Hospital and Hospital Related Services to the payment year will be the basis to determine the 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.

The final calculation to determine the additional DSH adjustment is summing the uncompensated care costs of the two components and reducing that amount by the graduate medical education reimbursement for public teaching hospitals (12(A)) determined for the same payment year.

"P&I" The additional DSH adjustment 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.

f. Disproportionate Share Payment Schedule

Hospitals qualifying for DSH payments under section (13d) 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 (13)e will receive quarterly payments of 1/4 of the amount determined under this section.

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 (13)e, 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 (13)d (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.

(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.

The State has in place a public process which complies with the requirements of Section 1902(a)(l3)(A) of the Social Security Act.

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.

F. HOSPITALS RECEIVING DRG PAYMENT'S – HOSPITAL BENEFIT DAYS AND REIMBURSEMENT

P&I The following service limitations will sunset on June 30, 2007.

P&I Individuals under the age of 21 have no hospital benefit day limits. Qualified Medicare Beneficiaries and Qualified Medicare-Medicaid Beneficiaries have no hospital benefit day limits. All other individuals are limited to 18 hospital benefit days per fiscal year.

Payments for inpatient services provided to an individual who is not subject to hospital benefit day limits admission are not prorated.

Full payment will be made if at least one hospital benefit day remains from the fiscal year in which the admission occurred at the time the claim is processed.

No payments will be made to any receiving hospital if a transfer to that hospital occurs after the benefit days have been used.

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.

OMAP will not make any additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the OMAP reimbursement, or 100 percent of billed charges.

8. UPPER LIMITS ON PAYMENT OF HOSPITAL CLAIMS

A. PAYMENTS WILL NOT EXCEED TOTAL OF BILLED CHARGES

Excepting for Type A hospitals which are reimbursed 100% of costs by Oregon statute, the total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost-outlier, capital, direct medical education, and indirect medical education payments shall not exceed the individual hospital's total billed charges for the period for these services.

If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total OMAP payment for those services, the overpayment shall be recovered.

B. PAYMENTS WILL NOT EXCEED FINALLY APPROVED PLAN

Total reimbursements to a State operated facility made during OMAP'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 OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

9. 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. OMAP will not reimburse for non-covered services. OMAP may disallow payment for physicians' services provided during patient hospitalizations for which prior approval was required but not obtained.

10. 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 OAR 410-120-780 through 410-120-1060 and OAR 410-125-2040 and 2060.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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 in the State Register by the Secretary of State.

SUBJECT: A description of the policy and the methods used in establishing payment rates for each type of care or service listed in Section 1905(a) of the Act.

Physician: Payment is based on a state-wide fee schedule based upon Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Dentist: A state-wide fee schedule was developed from a survey of other State Medicaid Programs and the major dental insurance carrier in Oregon.

Denturist: A state-wide fee schedule was developed from a survey of other State Medicaid Programs and the major dental insurance carrier in Oregon

Naturopath: Payment is on the same basis as Physician Services.

Direct Entry Midwives: Payment will be based on a state-wide fee schedule.

Acupuncturists: Payment will be based on a state-wide fee schedule.

Private Duty Nursing Services: Payment will be based on a state-wide fee schedule.

Nurse and Technician Anesthetists: Payment will be based on a state-wide fee schedule.

Chiropractor: Payment will be based on a state-wide fee schedule.

Podiatrists: Payment will be based on a state-wide fee schedule.

Physical Therapy: Payment will be based on a state-wide fee schedule.

Visual Care Services, examining and dispensing: Payment will be based on a state-wide fee schedule.

Eyeglasses, contacts and hardware: Payment will be based on a state-wide fee schedule.

Hospitalization in an Institution for Mental Disease: These institutions are reimbursed for the cost of impatient hospital services as prescribed in 42 CFR 447.253.

Home Health Services: Payment is based on a statewide fee schedule for each type of covered service. Medical supplies are covered at costs up to a specific dollar amount without prior authorization.

Ophthalmic Materials. Payment will be based on a state-wide fee schedule.

Medical Transportation. Payment will be based on a state-wide fee schedule

Medical Supplies and Equipment.

Aged, blind and disable persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Prosthetic Devices: Payment will be based on a state-wide fee schedule

Personal Care Services. Payments are made to individual providers based on state-wide uniform hourly rates or individually negotiated rates. The state-wide uniform hourly rates are supported by a survey of Oregon wages in comparable work and payment history. Payments are also made to agencies under a contract obtained through negotiation.

Occupational Therapy.

Aged, blind and disabled persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Audiologist Services.

Aged, blind and disabled persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Clinical Laboratory and Pathology Procedures.

Payment will be based on the lesser of Medicare's fee schedule or the Division's state-wide fee schedule.

Rehabilitative Mental Health Services

Payment will be based on a statewide fee schedule or prepaid capitation rates.

Rehabilitative Alcohol and Drug Services

Payment will be based on a statewide fee schedule or prepaid capitation rates.

Additional Services to Pregnant Women

Payment will be based on a statewide fee schedule.

EPSDT Services
The following describes the reimbursement methodologies for required EPSDT services not covered elsewhere in the plan:

Hospice payment and methodology is the same as used by Medicare's program.

Respiratory Care Services payment will be based upon Medicare principles of reimbursement.

Case Management Services reimbursement, for other than Targeted Case Management, will be based on a state-wide fee schedule with payment based on 15 minute time increments and billed on a monthly basis.

SP_REHAB

Preventive Services for HIV Infected Individuals

Payment will be based on a statewide fee schedule.

Hospice

Hospice payment and methodology is the same as used by Medicare's program and CMS guidelines issued annually that reflect rate adjustments. The Medicaid hospice payment base rates are calculated based on the annual hospice rates established under Medicare, 'I'hese rates are authorized by section I814(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.

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

P&I 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.

Prescribed Drugs

A. General

(1) The Department of Human Services (DHS) 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. DHS determines the EAC to be the lesser of: Oregon maximum allowable cost (as defined in B.2.), the federally established maximum allowable cost or the average wholesale price minus 15%, or average wholesale price minus 11% for institutional pharmacies. DHS determines usual charge to be the lesser of the following unless prohibited from billing by federal statute or regulation:

a. 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;

b. 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;

c. 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.

(2) The DHS requires prior authorization of payment for selected therapeutic classes of drugs. These drug classes are listed in the Oregon Administrative Rules in the Oregon Pharmaceutical Services Guide. Exception to the prior authorization requirement may be made in medical emergencies.

(3) The DHS 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) DHS 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) The DHS has established the payment amount for multiple source (generic) drugs as the lesser of the Oregon maximum allowable cost, CMS upper limits for drug payment, average wholesale price minus 15%, minus 11% for institutional pharmacies, plus a dispensing fee or the usual charge to the general public. Drugs purchased through the DHS mail order vendor is the lesser of the Oregon maximum allowable cost, CMS upper limits for drug payment, average wholesale price minus 60%, plus a dispensing fee.

(2) The Oregon Maximum Allowable Cost (OMAC) is determined on selected multiple-source drugs designated as bioequivalent by the Food and Drug Administration. The upper limit of payment for a selected multiple source drug is set at a level where one bioequivalent drug product is available from at least two wholesalers serving the State of Oregon. When the OMAC is based upon AWP it will be set at 15% below AWP, and below 11% for institutional pharmacies. The upper limit of is payment established by the OMAC listing does not apply if a prescriber certifies that a single-source (brand) drug is medically necessary.

(3) The average wholesale price is determined using information furnished by the DHS's drug price data base contractor.

(4) 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.

(5) No payment shall be made for an innovator multiple source drug having a federal upper limit for payment if under applicable Oregon State law a less expensive non-innovator multiple source drug could have been dispensed.

C. Payment Limits for Single-Source Drugs

(1) The DHS will pay the EAC plus a dispensing fee or the usual charge to the general public, whichever is lower, for single-source drugs. The DHS defines EAC for single-source drugs as the average wholesale price minus 15%, or minus 11% for institutional pharmacies. Drugs purchased through the DHS mail order vendor is the lesser of the Oregon maximum allowable cost, CMS upper limits for drug payment, average wholesale price minus 21%, plus a dispensing fee.

(2) The usual charge to the general public is established as indicated in A.(l).

(3) The average wholesale price is determined from price information furnished by the DHS's drug price data base contractor.

(4) 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. Dispensing or Professional Fees

(1) The DHS establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies and other Medicaid programs, and by approval of the State Legislature.

(2) The present dispensing fee payment mechanism is two tiered. The base fee is $3.50 for retail pharmacies, $3.91 for institutional or pharmacies dispensing with a true or modified unit dose dispensing system. The pharmacy must provide documentation substantiating annual, Medicaid dispensing volume and unit dose dispensing system employed.

(3) Pharmacies dispensing through a unit dose or 30-day card system must bill the DHS only one dispensing fee per medication dispensed in a 30-day period.

(4) Compound prescription fee allowances are made for preparation time and dispensing. A prescription is considered a compound prescription when it is prepared in the pharmacy by combining two or more ingredients and involves the weighing of at least one solid ingredient or a legend drug in a therapeutic amount. Pharmacies will receive a dispensing fee of $7.50 for a compound, which contains two, or more ingredients listed in the compound. Pharmacies must list all applicable NDC numbers included in the compound.

(5) A 340B program to be phased in starting with a single clinic and adding covered entities if program is determined to be successful. The Department will establish a $10 dispensing fee and reimbursement as follows: the lesser of the acquisition cost, the federal upper limit, the Oregon Maximum Allowable Cost, or federal 340B pricing. A method to identify claims for exclusion from CMS rebate collections will be developed.

Payment Methodology for Targeted Case Management for Persons with Developmental Disabilities

The Mental Health and Developmental Disability Services Division (the Division) established an initial monthly statewide rate for regular case management services for persons with developmental disabilities in 1989. The rate was based on the total average monthly cost per client served by each case manager and included all direct service and administrative costs associated with case management service delivery under ideal caseloads. The Division has adjusted the rate annually for cost of living changes. The Division has the option to adjust for expenditure changes, as needed, through use of the following targeted case management contract language: "If asked to assist DIVISION with rate computations, COUNTY agrees to submit detailed information on expenditures as specified by the DIVISION."

Providers of regular case management bill the Division at the prevailing monthly rate. Beginning in 1994, providers of the new intensive case management may bill the Division at a higher monthly rate. Billings for both types of providers flow through the Division's Client Process Monitoring System (CPMS). CPMS provides all required information, including:

Date of Service;
Name of Recipient;
Name of Provider Agency and Person Providing the Service;
Nature, Extent, or Units of Service; and
Place of Service.

The Division advances State General Funds to each community mental health program on a monthly basis. This monthly advance equals 1/12 of their annual allocation. Case Managers document the provision of case management services to clients enrolled in CPMS. The Division then compares CPMS information to the state Medicaid eligibility tape to identify Medicaid eligible clients and bills Medicaid for regular or intensive case management services. The Division monitors General Fund advances and Medicaid billings and makes adjustments as necessary.

The community mental health programs submit cost statements to the Division as requested. Rate re-computations (separate from normal cost-of-living adjustments) are conducted as described below:

Rate Computation Methodology

The rate for reimbursement of the case management services is computed as follows:

Compute the	Annual Case Manager salary and fringe benefits
Plus	Other operating cost including travel, supplies, telephone, and occupancy cost
Plus	Direct supervisory cost
Plus	Average indirect administrative cost of provider organization
Equals	TOTAL ANNUAL COST PER CASE MANAGER
Divided by	12
Equals	MONTHLY COST PER CASE MANAGER
Divided by	Number of clients to be served during month
Equals	TOTAL MONTHLY COST PER CLIENT

The total cost per case manager is the sum of the case manager's salary, direct supervisory costs, indirect administrative costs of the provider organization and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average monthly cost per case manager. Dividing the monthly cost per case manager by the number of clients to be served during the month results in the total monthly costs per client for regular and for intensive case management. These two figures are the monthly statewide reimbursement rates.

In setting the regular and intensive case management rates, the Division uses ideal caseloads to estimate the number to be served relative to the need. For intensive case management, the Division uses a lower ideal caseload ratio to reflect higher service need (severity). This makes possible the provision of case management services such as: 1) transition planning and coordination of services for clients moving from school to employment (the employer provides natural supports); and 2)coordination of services to clients in their family home to avoid institutionalization. When clients with developmental disabilities no longer need intensive case management, the Division serves them through regular case management.

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.

Payment methodology for targeted case management providers will be computed in the following manner:

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.

TN # 91-15 DATE APPROVED 1/10/92
SUPERSEDES EFFECTIVE DATE 7/1/91
TN # -----

Payment Methodology for Targeted Case Management for Medicaid High Risk Infants and Children

Payments for targeted case management services for Medicaid high risk infants and children (0 - 3 years of age) are made on a fee-for-service basis. Rates are based on a statewide fee schedule.

Payment Methodology for Targeted Case Management
for Persons with HIV Disease

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 actual cost of providing the monthly service.

Payment Methodology for Targeted Case Management for Medicaid Eligible Substance Abusing Pregnant Women and Women with Young Children

Payments for targeted case management services for Medicaid eligible women in the target group are made on a fee-for-service basis. Rates are based on a statewide fee schedule.

Payment Methodology for Mental Health Targeted Case Management

"Unit" is defined as a 15-minute increment. 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.

Payment for mental health targeted case management will be made based upon a statewide fee schedule. The fee schedule will be two-tiered based upon the difference in case manager qualifications. The costs used to derive the targeted case management rate will be limited to the identified costs per provider divided by the number of service hours per month expressed in 15-minute increments.

Targeted case management costs, direct and related indirect costs that are paid by other Federal or State programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report.
The rate in the first year is established on a prospective basis. For subsequent years, the rate will be based on actual case management costs from the previous year. 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.

Payment Methodology for Tribal Targeted Case Management

"Unit" is defined as a month. 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.

Payment for tribal targeted case management will be made using an estimated monthly rate based on the total average monthly cost per client served by the provider during the last fiscal year for which audited financial statements have been filed with the Department. The costs used to derive the monthly tribal targeted case management rate will be limited to the identified costs divided by the number of clients served. Tribal targeted case management costs, direct and related indirect costs that are paid by other Federal or State programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. 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 served. For subsequent years, the rate will be based on actual case management costs from the previous year. 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.

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, except for clinical laboratory. The interim payment for clinical laboratory is the lesser of billed charges or the OMAP fee schedule. A cost settlement based on the most recent finalized Medicare cost report is then applied to Medicaid covered charges billed and paid for the cost reporting year. 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 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, except for clinical laboratory . The interim reimbursement for clinical laboratory is the lesser of billed charges or the OMAP fee schedule. A cost settlement based on the most recent finalized Medicare cost report is then applied to Medicaid covered charges billed and paid for the cost reporting year. The final reimbursement for each DRG hospital is then calculated by applying an administratively established percentage to the costs. This calculation results in these hospitals receiving less than 100% of costs.

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 OMAP fee schedule. There is no cost settlement.

Effective December 1, 2002, in state fiscal years the Department of Administrative Services, will determine the aggregate reduction or increase required to meet the projected budget. The adjustment percentage will be determined by dividing the aggregate reduction or increase by the current outpatient hospital budget resulting in an adjustment percentage. The current percentage will then be multiplied by the adjustment percentage to determine the net percentage. This net percentage will be applied to each hospital's current reimbursement percentage to determine the new reimbursement percentage for the out-of-state hospitals. The Department, in accordance with 42 CFR 447.205, will make public notice of changes whenever a reimbursement adjustment is made under the provision of the section.

Highly specialized out-of-state outpatient services are provided by written agreement or contract between OMAP 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.

OUTPATIENT HOSPITAL SERVICES (Continued)

Outpatient 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 Outpatient 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 payment is calculated by the determination of the Medicare upper payment limit of Medicaid Fee-For-Service Outpatient charges converted to what Medicare would pay, less Medicaid payments, third party liability payments, and the net Outpatient cost settlement payment determined in the Medicaid Cost Settlement (Form 42). The State of Oregon Medicaid Management Information System (MMIS) and the provider's Medicare Cost Report are the source of the charge and payment data.

Outpatient Proportionate Share payment will be made annually following the finalization of the Medicaid Cost Settlement. The Outpatient Proportionate Share payment will not exceed the Medicare upper payment limit calculated from January 1, 2001 through
P&I September 30, 2001 and annually for each state fiscal year thereafter

On and after January 1, 2005 the outpatient proportionate share will be calculated using the Medicare aggregate upper payment limit and the Medicaid Cost Settlement.
P&I Payments made during the state fiscal year will not exceed the Medicare aggregate upper payment limit calculated from January 1, 2005 through September 30, 2005 and annually for each state fiscal year thereafter.

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.

Independent Rural Health Clinic (RHC) Alternate Payment Methodology (APM) for Obstetrics (OB) Care Delivery Procedures

(1) A Medicare certified independent RHC, as defined below, may be eligible for an obstetrics (OB) alternate payment methodology (APM) encounter rate for delivery procedures. The OB APM delivery encounter rate includes additional OB delivery-related costs incurred by a clinic as a cost-based payment in addition to the Prospective Payment System (PPS) medical encounter rate. The intent of the OB APM is to maintain access to OB care, including delivery services, in frontier and remote rural areas and to compensate eligible clinics for professional costs uniquely associated with OB care, not to exceed 100% of reasonable cost.

(1) To be eligible for the OB APM delivery encounter rate, a Medicare certified independent RHC must meet all Office of Medical Assistance Programs (OMAP) requirements applicable to an RHC, qualify as either “frontier” or “remote rural” as defined in (a) and (b) below, be located in a service area with unmet medical need defined in (c) below, and must request to participate in writing pursuant to participation requirements specified in (3) and (5) below.
- (a) Frontier RHC is defined as located in a frontier county as designated by the Oregon Office of Rural Health;
- (b) Remote rural RHC is defined as located in a remote rural service area as designated by the Oregon Office of Rural Health;
- (c) A frontier or remote rural RHC must be located in a service area of unmet medical need as determined by the Oregon Office of Rural Health for the year in which the written request for OB APM was made.

(2) If the frontier or remote rural RHC qualifies under (2) and other requirements outlined by OMAP, the clinic must submit a written request to OMAP including all required documentation necessary to qualify for the OB APM delivery encounter rate in (5) below.

(3) Care status changes:
- (a) OMAP reserves the right to request periodic review of utilization, cost reporting and to re-evaluate OB care access including delivery services in a community to determine the continued need to pay an OB APM delivery encounter rate for frontier and remote rural RHCs;
- (b) Prior to making any changes in the RHC’s status and rates, OMAP will re-evaluate the following:
  - (i) If OB care access including delivery services in a community has changed;
  - (ii) If the RHC no longer meets the requirements for the OB APM:
    - (A) An RHC’s agreement with the Secretary of Health and Human Services, Center for Medicare and Medicaid Services is terminated, or
    - (B) The location of an RHC does not qualify as an unmet medical need service area as determined by the Oregon Office of Rural Health for five consecutive years;
  - (iii) The stability of new providers supplying additional OB care access including delivery services.

(4) Determining OB APM Delivery Encounter Rate: The frontier or remote rural RHC requesting an OB APM delivery encounter rate, and meeting the OMAP requirements, will have an OB APM delivery encounter rate which is the sum of a clinic's PPS medical encounter rate and an OB cost-based payment. The OB payment is calculated from costs uniquely associated with OB delivery services and which were not used in the calculation of a clinic's PPS medical encounter rate as outlined in the state plan.

(a) Qualification of the OB APM delivery encounter rate is not considered a change of scope.

(b) The Medicare Economic Index (MEI) adjustment, as required by the PPS, will apply to the OB APM delivery encounter rate once established.

(c) OMAP will use the information listed below to determine the eligible RHC's initial OB payment. With the written request for an OB APM delivery encounter rate, both an existing and new clinic must provide:
   (i) Total number of delivery encounters;
   (ii) Malpractice premiums for all physicians and certified nurses performing OB deliveries for the current and next year; and
   (iii) On-call time coverage.

(d) Delivery encounters include vaginal and cesarean delivery professional services provided by the RHC.
   (i) Clinics performing deliveries prior to written request for an OB APM delivery encounter rate must provide the most recent full year of claims data for deliveries; and
   (ii) Clinics that have not previously provided delivery services must provide a reasonable projection of delivery encounters for the forecasted year.
   (iii) Clinics with actual or projected delivery encounters less than 100, will have their OB payment calculated using a base number of 100 OB delivery encounters.

(e) OMAP will calculate an additional projected cost of malpractice (liability) premiums to be included in the OB cost-based payment, outside of costs included and which have already been accounted for in the PPS medical encounter rate, as follows:
   (i) For both an existing and new clinic, OMAP will calculate malpractice premiums that are based on the average costs for the current and next year based on the date the clinic applies for the OB APM delivery encounter rate, as projected by the RHC's malpractice carrier. Costs are the premiums the clinic or individual actually pays, accounting for any reductions or credits.
   (ii) For existing clinics, OMAP will determine the malpractice premiums reported for physicians and certified nurses performing OB deliveries when the RHC initially enrolled with OMAP and the PPS medical encounter rate was calculated. Premium amounts used in the initial PPS medical encounter rate calculation will be adjusted by the MEI for each subsequent year of enrollment, up to the year of written request for an OB APM delivery encounter rate. The premium(s) adjusted by MEI is an amount included in the current PPS medical encounter rate.

(iii) For new clinics, OMAP will determine the actual malpractice premiums for OB physicians and certified nurses performing OB deliveries for the current year.

(iv) OMAP will subtract the premiums calculated in either (ii) or (iii) above, and accounted for in the calculation of the clinic's PPS medical encounter rate, from the average cost of OB malpractice premiums in (i) above, to calculate the projected portion of OB malpractice premiums to be included in calculating the OB payment.

(f) OMAP will calculate the cost of physician on-call time for OB care by multiplying a clinic's adjusted OB on-call hours of coverage by the fixed rate of $20.00 per hour. A clinic's adjusted OB on-call coverage hours will be calculated as follows:

(i) Reducing total clinic coverage hours per year by the clinic daily office hours, and

(ii) Reduced by physician vacation hours, and

(iii) Calculated at 60 percent of adjusted on-call time.

(g) The OB payment will be the sum of the difference of averaged malpractice premiums and current actual premiums (e), and the cost of on-call coverage (f), divided by the total number of OB care delivery encounters (d).

(h) The OB APM delivery encounter rate is the sum of the OB payment (g) and the PPS medical encounter rate.

(5) Rural Health Clinics providing managed care services are provided a supplemental payment by the state so that total payments to an RHC are at full cost as required by federal statute. The state payment reconciliation process for such supplemental payments occurs as follows:

(a) RHC bills managed care organization (MCO) for costs;

(b) MCO pays RHC the rate paid to any other provider for like services;

(c) RHC submits claims data to OMAP;

(d) OMAP matches RHC claims data with MCO encounter data;

(e) OMAP pays the difference up to the OMAP established PPS or APM delivery encounter rate if the amount received from the MCO is less, to ensure RHC is paid 100% of reasonable costs.

Nurse Practitioner Services

Payment will be based upon a state-wide fee schedule.

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.

<u>Enhanced Teaching Physician and Other Practitioners Fee-For-Service Reimbursement:</u>

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.