DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX-43
Seattle, Washington 98121

January 7, 2010

Bruce Goldberg, MD, Director
Division of Human Services
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

RE: Oregon State Plan Amendment 09-015

Dear Dr. Goldberg:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Oregon State Plan Amendment (SPA) 09-015.

Although the NIRT Team has already sent the State a copy of the approval for this SPA, the Seattle Regional office is following up with an additional copy for the reason that we were in receipt of the original, signed amendment request.

Therefore, enclosed you will find a copy of the official CMS form 179, amended page(s), and copy of the approval letter from the NIRT Team for your records.

If you have any questions concerning the Seattle Regional office role in the processing of this state plan amendment, please contact Daphne Hicks at (206) 615-2400 or daphne.hicks@cms.hhs.gov.

Sincerely,

[redacted]

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

Cc: Judy Mohr Peterson, Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-15**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447, Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2010 $247,433,073~~ 2009 $(2,674,389) (p+I)
b. FFY ~~2011 $247,433,073~~ 2010 $(10,697,555) (p+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Part 1, Pages 1-12

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, Part 1, Pages 1-12

10. SUBJECT OF AMENDMENT: This transmittal is being revised to limit the administrative and property cost components on Nursing Facilities.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Judy Mohr-Peterson / Bruce Goldberg, MD

14. TITLE: Administrator, DMAP / Director, DHS

15. DATE SUBMITTED:

16. RETURN TO:
Division of Medical Assistance Programs
Department of Human Services
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, Title XIX Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2009

18. DATE APPROVED: JAN 06 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2009

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Barbara K Richards

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:
11/17/2009 State authorized pen & ink changes.

FORM HCFA-179 (07-92)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and State Operations , CMSO

Bruce Goldberg, MD, Director
Division of Human Services
Human Services Building
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

JAN - 6 2010

RE: OR 09-015

Dear Secretary Goldberg:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-015. This amendment updates the State plan by limiting the administrative and property cost components of the per diem rate for nursing facility services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-015 is approved effective July 1, 2009. We are enclosing the HCFA-179 and the amended pages.

If you have any questions concerning this State plan amendment, please call Joe Fico of the National Institutional Reimbursement Team at (206) 615-2380.

Sincerely,

Bill Lasonal

Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

Enclosures

cc: Judy Mohr-Peterson, Administrator, OMAP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Judy Mohr-Peterson / Bruce Goldberg, MD

14. TITLE: Administrator, DMAP / Director, DHS

15. DATE SUBMITTED:

16. RETURN TO:
Division of Medical Assistance Programs
Department of Human Services
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, Title XIX Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2009

18. DATE APPROVED: 1-6-2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:
11/17/2009 State authorized pen and ink changes.

FORM HCFA-179 (07-92)

NURSING FACILITIES

Reimbursement for services provided by Nursing Facilities is made by means of rates determined in accordance with the following principles, methods, and standards which comply with 42 CFR Part 447, Subpart C.

I. Reimbursement Principles.

The payment methodology is based on the following:

A. Reimbursement by the Senior and People with Disabilities Division of the Department of Human Services is based on a prospective, all-inclusive rate system which constitutes payment in full for services which are not reimbursed through another Medicaid payment source. The rates established for these long-term care services include reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Costs which are or can be reimbursed by Medicare Part B or a third party payor are not allowed;

B. A standard, statewide flat rate which bears a fixed relationship to reported allowable costs;

C. A complex medical needs add-on rate which bears a fixed relationship to the standard flat rate;

D. A pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit; and

E. Annual review and analysis of allowable costs for all participating nursing facilities. Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident care.

F. All Nursing Facility Financial Statements are subject to desk review and analysis to determine that the provider has included its costs in accordance with Generally Accepted Accounting Principles and the provisions of the Oregon Administrative Rules.

II. Nursing Facility Rates.

A. The Basic Rate.

1. The Division shall pay the basic rate to a provider as prospective payment in full for a Medicaid resident in a nursing facility.

2. "Basic rate" means the standard, statewide payment for all long term care services provided to a resident of a nursing facility except for services reimbursed through another Medicaid payment source.

3. The basic rate is an all-inclusive rate constituting payment in full, unless the resident qualifies for the complex medical needs add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate). The methodology for calculating the basic rate is described in Section III.

B. The Complex Medical Needs Add-on Rate.

1. If a Medicaid resident of a nursing facility qualifies for payment at the basic rate and if the client's condition or care needs are determined to meet one or more of the medication procedures, treatment procedures or rehabilitation services described in paragraph 2 of this subsection, the Division may pay the basic rate plus the complex medical add-on rate for the additional licensed nursing services needed to meet the client's increased need to a provider as prospective payment in full.

2. "Complex Medical Needs Add-on Rate" means the standard, statewide supplemental payment for a Medicaid client of a nursing facility whose care is reimbursed at the basic rate if the client needs one or more of the following medication procedures, treatment procedures or rehabilitation services for the additional licensed nursing services needed to meet the client's increased needs.

a. Medication Procedures

(1) Administration of medication(s) at least daily requiring skilled observation and judgment for necessity, dosage and effect for example new anticoagulants, etc. (This category does not include routine medications, any oral medications or the infrequent adjustments of a current medications);

(2) Intravenous injections/infusions, heparin locks used daily or continuously for hydration or medication;

(3) Intramuscular medications for unstable condition used at least daily;

(4) External infusion pumps used at least daily. This does not include external infusion pumps when the client is able to self bolus;

(5) Hypodermoclysis daily or continuous use;

(6) Peritoneal dialysis, daily. This does not include clients who can do their own exchanges;

b. Treatment Procedures

(1) Nasogastric,Gastrostomy or Jejunostomy tubes used daily for feedings;

(2) Nasopharyngeal suctioning twice a day or more. Tracheal suctioning as required for a client who is dependent on nursing staff to maintain airway;

(3) Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more often;

(4) Care and services for a ventilator dependent client who is dependent on nursing staff for initiation, monitoring, and maintenance;

(5) Is limited to Stage III or IV pressure ulcers which require aggressive treatment and are expected to resolve. The Pressure Ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer;

(6) Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily, which require aggressive treatment and are expected to resolve;

(7) Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. Eligible for add-on until the last day the ulcer is equivalent to a Stage III. If the stasis ulcer is chronic, it is eligible for add-on only until it returns to previous chronic status.

(8) Unstable Insulin Dependent Diabetes Mellitus (IDDM) in a client who requires sliding scale insulin; and

(i) Exhibits signs/symptoms of hypoglycemia and/or hyperglycemia; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

While all three criteria do not need to be present on a daily basis, the client must be considered unstable. A Client with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(9) Professional teaching. Short term, daily teaching pursuant to discharge or self-care plan;

(10) Emergent medical/surgical problems requiring short term licensed nursing observation and/~~or~~ assessment. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical/surgical problem); or

(11) Emergent behavior problems which involve a sudden, generally unexpected change or escalation in behavior of a client that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and care planning. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical problem);

c. Rehabilitation Services. Utilization of rehabilitation services in the frequencies specified below are used only to determine qualification for payment of the "complex Medical Needs Add-On Rate". No separate reimbursement will be made for these services outside the approved State Plan.

(1) Physical therapy performed at least 5 days every week;

(2) Speech therapy performed at least 5 days every week;

(3) Occupational therapy performed at least 5 days every week;

(4) Any combination of physical therapy, occupational therapy and speech therapy performed at least 5 days every week; or

(5) Respiratory Therapy at least 5 days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan or a third party payor.

3. The basic rate plus the complex medical needs add-on rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for a supplemental payment for complex medical care in addition to the basic rate. The methodology for calculating the basic rate is described in Section III.

C. Pediatric Rate.

1. Notwithstanding subsections A and B, if a Medicaid resident under the age of 21 is served in a "pediatric nursing facility" or a "self-contained pediatric unit", as those terms are defined in Section III.C. the Division shall pay the pediatric rate stated in Section III.C.2. as prospective payment in full.

2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.

3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

D. Other Payments.

1. Medicare. The Division shall pay the coinsurance rate established under Medicare, Part A, Hospital Care for care rendered to an eligible client from the 21st through the 100th day of care in a Medicare certified nursing facility.

2. Swing Bed Eligibility. To be eligible to receive a Medicaid payment under this rule, a hospital must:

(a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed provider agreement with the Seniors and People with Disabilities Division to receive Medicaid payment for swing-bed services.

(1) NUMBER OF BEDS:

(a) A Critical Access Hospital (CAH) that is not located within a 30 mile geographic radius of a licensed nursing facility as of March 13, 2007 may provide swing bed services to up to 20 Medicaid residents at one time. The CAH must maintain at least five beds or twice the average acute care daily census, whichever is greater, for exclusive acute care use;

(b) Other hospitals providing swing bed services under this rule may not receive provide such services to more than five Medicaid residents at one time. In addition, the residents must have a documented need for and receive services that meet the complex medical add-on requirements outlined in OAR 411-070 as of July 1, 2009, This OAR contains relevant details of the States's NF reimbursement methodology and as such is adhered to by the State;

(c) If circumstances change so that a CAH receiving payment for Medicaid services pursuant to section (2)(b) of this rule meets the criteria set out in section (2)(a) of this rule after March 13, 2007, the CAH may petition the Division for authorization to receive such payment pursuant to section (2)(a) of this rule. The Division will evaluate all available long-term care resources within a 30 mile geographic radius of the CAH and the amount of unmet long-term care need in the same area and determine if the CAH will be authorized to receive payment pursuant to section (2)(a) of this rule.

(2) PAYMENT:

(a) Daily Rate. Medicaid payment for swing-beds will be equal to the rate paid to Oregon's Medicaid certified nursing facilities.

(b) Medicare Co-payment. Medicaid payment for Medicare co-insurance for Division clients will be made at a rate which is the difference, if any, between the Medicare partial payment and the facility Medicaid rate.

(3) ADMISSION OF CLIENTS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager must determine there is no nursing facility bed available to the client within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" means a bed in a nursing facility that is available to the client at the time the placement decision is made.

3. Out-of-State Rate. When an Oregon Medicaid resident is cared for temporarily in a nursing facility in a state contiguous to Oregon while an appropriate in-state care setting is being located, the Division shall pay the lesser of:

   a. The Medicaid rate for the resident's level of care established by the state in which the nursing facility is located; or

   b. The rate for which the resident would qualify in Oregon which is either the Basic Rate with a possible Complex Medical Needs Add-on payment or an Extreme Outlier Client Add-on payment, or the pediatric rate.
   c. In order to approve a temporary out-of-state rate, the Division must be furnished a written statement from the resident's physician that specifies an anticipated date of discharge or length of stay.

4. Outlier Client Add-On

   a. The Division may make an outlier client add-on payment when a client has a combination of extraordinary medical, behavioral and/or social needs and no satisfactory placement can be made within the established payment categories.

   b. The add-on will be specific to the client's care needs, based on an outlier care plan approved by the Division at the beginning of outlier care and at six month intervals thereafter, and the facility-specific direct care costs related to the client's outlier care plan.

c. The outlier add-on will be calculated using the latest audited facility-specific unit price of the direct care component(s) whose costs are increased due to the outlier care plan.

5. Nurse Aide Training and Competency Evaluation.

The administrative expenses incurred by nursing facilities for nurse aide training and competency evaluation will be reported on a quarterly basis, and the facility will be reimbursed the eligible portion of these costs. Payments made under this provision will be on a pass-through basis outside the approved reimbursement system.

6. Trustee.

When a trustee is appointed temporarily by the court to manage a facility for protection of the health and welfare of residents, costs related to the operation of the facility which are not covered by the facility's revenue sources, including regular Medicaid rates and the State's trust fund, will be reimbursed as administrative costs under Section 6.2 of the approved State Plan.

7. Certified Nursing Assistant (CNA) Staffing Standard.

a. The Division shall add to the basic rate and the pediatric rate a Certified Nursing Assistant staffing standard payment to work toward implementation of a new minimum CNA staffing standard of 2.46 hours per resident day (HPRD).

(1) Raise HPRD to 2.07 on March 1, 2008

(2) Raise HPRD to 2.31 on April 1, 2009

(3) Raise HPRD to 2.46 on July 1, 2009

b. The Division shall collect quarterly staffing updates from nursing facilities and monitor staffing compliance.

III. Financial Reporting, Facility Auditing, and the Calculation of the Standard Statewide Basic Rate and Complex Medical Needs Add-on Rate.

A. Financial Reporting and Facility Auditing.

1. Effective July 1, 1997, each facility files annually and for the period ending June 30 a Nursing Facility Financial Statement (Statement) reporting actual costs incurred during the facility's most recent fiscal reporting period. The Statement can be filed for a reporting period other than one year only when necessitated by a change of ownership or when directed by the Division.

2. Each Statement is subject to desk audit within six months after it has been properly completed and filed with the Division. The Division may conduct a field audit which, if performed, will normally be completed within one year of being properly completed and filed with the Division.

B. Calculation of the Standard Statewide Basic Rate and Complex Medical Needs Add-on Rate.

1. Basic Rate and Complex Medical Needs Add-on Rate.

a. Basic Rate. For the first year of each biennium (the Rebasing Year), the Basic Rate is based on the Statements received by the Division by September (or postmarked by October 31, if an extension of filing has been approved by the Division) for the fiscal reporting period ending on June 30 of the previous even-numbered year, e.g., for the biennium beginning July 1, 1999, Statements for the period ending June 30, 1998 are used. Statements for pediatric nursing facilities are not used to determine the Basic Rate. The Division desk reviews or field audits these Statements and determines for each nursing facility, its allowable costs less the costs of its self-contained pediatric unit, if any.

For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the first year of the biennium, hereafter referred to as the Base Year (e.g., for the biennium beginning July 1, 1999, the Base Year is the fiscal period ending June 30, 2000) by projected changes in the DRI Index.

For each facility, its Allowable Costs Per Medicaid Day is determined using the allowable costs as inflated and resident days excluding days in a self-contained pediatric unit as reported in the Statement.

The Basic Rate for the second year (Non-Rebasing Year) of the biennium is the Basic Rate for the first year, inflated by the DRI Index.

c. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Basic Rate.

2. For the 2009 rebasing period only, the Department will limit the administrative and property cost components as follows:

a. Administrative and General costs per facility, less provider tax and employee benefits, equals the lesser of the facility's allowable cost or the 50th percentile over all facilities; and

b. When the occupancy percentage is less than 60 percent, allowable property expenses will equal the lesser of the facility's allowable expenses multiplied by the Medicaid occupancy percentage.

3. For the period beginning July 1, 2003 through June 30, 2005, new Basic Rates are computed by arraying the allowable costs of all facilities appropriate to be included in the rebasing calculation, and setting the Rate at the 63rd percentile of allowable costs (both direct and indirect).

4. For the period beginning July 1, 2005 through June 30, 2007, the Rate is set at the 70th percentile of allowable costs (both direct and indirect).

5. For the period beginning July 1, 2007 through June 30, 2013, the Rate is set at the 63rd percentile of allowable costs (both direct and indirect).

6. The Basic Rate established in steps 3 and 5 above is inflated by the DRI Index in the second year (the Non-Rebasing Year).

7. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on rate is 40 percent of the Basic Rate.

C. Pediatric Nursing Facilities.

1. Pediatric nursing facility means a licensed nursing facility, 50% of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

2. Pediatric nursing facilities will be paid a per diem rate of $188.87 commencing on August 1, 1999, which rate will:

a. Be prospective;

b. Not be subject to settlement; and

c. The per diem rate will be calculated as follows:

The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days.

The base year will be 1998. Once the weighted average cost is determined, the rebase relationship percentage (90.18%), determined in the implementation of the flat rate system in 1997, is applied to set the new rate. Before computing the weighted average cost, the facility-specific total costs are inflated by a change in the DRI Index to bring the cost to the rebase year.

On July 1 of each non-rebase year after 1999, the pediatric rate will be increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate setting will occur in alternate years. Rebasing of pediatric nursing facility rates will be calculated using the method described above.

3. Pediatric nursing facilities must comply with all requirements relating to timely submission of Nursing Facility Financial Statements.

D. Licensed Nursing Facility With a Self-Contained Pediatric Unit.

1. A nursing facility with a self-contained pediatric unit means a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility.

2. Nursing facilities with a self-contained pediatric unit will be paid in accordance with subsection C.2. of this section for pediatric residents cared for in the pediatric unit.

3. Nursing facilities with a self-contained pediatric unit must comply with all requirements related to timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.

IV. Public Process

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.