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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 10-01

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

January 18, 2017

Lynne Saxton, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number 10-001

Dear Ms. Saxton:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oregon State Plan Amendment (SPA) Transmittal Number 10-001. This SPA is being submitted to revise the reimbursement methods for the Targeted Case Management (TCM) program for Self Sufficiency.

This SPA is approved effective January 1, 2010.

If there are additional questions please contact me, or your staff may contact Bill Vehrs at bill.vehrs@cms.hhs.gov or at (503) 399-5682.

Sincerely,

Digitally signed by David L. Meacham
-S

[redacted]

David L. Meacham
Associate Regional 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: **10-01**

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
January 1, 2010

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 440.169

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $ 1,558,236
b. FFY 2011 $ 1,950,128

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
40-44(P&I)
Supplement 1 to attachment 3.1-A, page ~~40-43,~~ ~~attachment 4.19B, page 41~~ ~~4n, 4o, 4p(P&I).~~ (P&I)
Attachment 4 19B, page 4l, 4m, 4n, 4o,4p (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment to Supplement 1 to Attachment 3.1-A, pages 4-6 (P&I)
~~Supplement 1 to attachment 3.1-A, page 4-6,~~ (P&I)
~~attachment 4.19B, page 4b~~ (P&I)

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to revise reimbursement methods for self sufficiency TCM program.

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~~ [redacted]

14. TITLE: Administrator, DMAP ~~Director, DHS~~ [redacted]

15. DATE SUBMITTED: 3/17/10

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: MAR 17 2010

18. DATE APPROVED: 1/18/2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/2010

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:

3/31/2010 State authorized pen and ink changes to box 9.
7/12/2010 State authorized pen and ink changes to box 8.
11/21/16 - State authorized P&I change to box 8
1/18/17 - State authorized P&I change to box 9

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Targeted Case Management-Children, Adults and Families (CAF) Self sufficiency

Target Group:

Medicaid eligible parents age 14 and over who receive Temporary Assistance to Needy Families (TANF) benefits.

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☒ 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)

Comparability of services:

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

☒ Services are not comparable in amount duration and scope.

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.

Definition of services:
Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

TCM- CAF Self sufficiency-Continued

Comprehensive assessment and periodic reassessment of individual needs:
These annual assessment (more frequent with significant change in condition) activities include:

- Taking client history;
- Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

*Referral and related activities***:**
To help an eligible individual obtain needed services including activities that help link and individual with:

- Medical, social, educational providers; or
- Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.

Monitoring and follow-up activities:
Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

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TCM- CAF Self sufficiency-Continued

Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

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:

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.

Provider Organizations(cont):

- 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.

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.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

TCM- CAF Self sufficiency-Continued

Freedom of Choice (42 CFR 441.18(a)(1):
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. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
☐ Target group consists of eligible individuals with developmental disabilities Program or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.[42 CFR 431.10(e)]

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted 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 Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

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TCM- CAF Self sufficiency-Continued

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State/Territory: ___OREGON_____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Targeted Case Management for Children, Adults and Families Self sufficiency

Targeted Case Management (TCM) services provided to Medicaid eligible parents age 14 and over who receive Temporary Assistance to Needy Families (TANF) benefits are delivered by DHS employed case managers (herein after referred to as "providers" for this section of the State Plan).

Reimbursement Methodology:

Claiming is based on the actual cost of providing the TCM service as determined using a federally approved Random Moment Time Study (RMTS) and Public Assistance Cost Allocation Plan (PACAP). The RMTS is used to determine what portion of the provider's time is spent performing covered TCM activities. The percentage of time is applied to a "cost pool", limited to TCM providers, in the PACAP to determine the cost of providing the TCM service. All qualified providers are included in the sample universe for the HHS-approved time study and only providers identified in the approved State plan may be included in the cost pool for the time study.

Cost Allocation is used by DHS to determine appropriate claiming of federal and other funding sources for all benefiting programs.

The total direct and indirect cost of providing TCM services, as determined by RMTS and Cost Allocation, is reported on the CMS-64 Quarterly Expense Report.

Data Capture for the Cost of Providing TCM Services:

Data capture to determine the total direct and indirect cost of providing TCM services will be captured utilizing the data sources listed below:

1. Random Moment Time Study (RMTS) activity codes provided in Appendix C, Part D, Section 4, of the State's approved Public Assistance Cost Allocation Plan; and

2. The percentage of time spent on covered TCM activities as determined by the RMTS, applied to the approved PACAP to determine the applicable indirect portion.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

TCM- CAF Self sufficiency

Data Sources and Cost Finding Steps:

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs

   Direct costs for TCM services include unallocated payroll costs and other unallocated costs that can be directly charged for TCM services. Unallocated costs are those expenses that are assigned to one single cost objective in the cost allocation plan. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation). These direct costs will be calculated on a provider-specific level and are determined using an approved RMTS to determine the percentage of time spent providing covered TCM activities. Other direct costs include costs directly related to the approved direct services personnel for the delivery of TCM services, such as services, supplies and materials. Appendix C, Part E of the State's PACAP contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

   The source of this financial data will be audited Chart of Account records kept at the provider level. The Chart of Accounts is uniform throughout the state of Oregon. Costs will be reported on an accrual basis.

2. Indirect Costs

   Indirect costs are determined by applying the approved indirect percentage to the adjusted direct costs. The indirect cost rate percentage is an amount that comes from the federally approved rate agreement on file with the federal HHS Cost Allocation Services.

3. Time Study Percentages

   A CMS-approved time study is used to determine the percentage of time that personnel spend providing covered TCM activities, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results will be applied to the TCM services cost pool. The TCM services costs and time study results must be aligned to ensure proper cost allocation. The use of CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per OMB Circular A-87 cost allocation requirements.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

TCM- CAF Self sufficiency

4. Total Medicaid Reimbursable Cost

The result of the previous steps will be a total Medicaid reimbursable cost for each provider for Targeted Case Management services.

5. Cost Settlement:
Claims paid during the previous 12 months/reporting period, as documented in MMIS and in the Cost Allocation Plan, will be compared to the total Medicaid allowable cost for targeted case management services delivered by DHS according to the methodology described in this attachment. Any amounts due to or from the State Medicaid Agency will be adjusted in the aggregate, which results in cost reconciliation. Reconciliation will occur within 24 months of the last day of the reporting period. If it is determined that an overpayment has been made, the State will return the federal share of the overpayment. If the actual certified Medicaid allowable costs of targeted case management services delivered by the sister state agency exceed the amounts which have already been claimed during the reporting period, the State will submit claims to CMS for the underpayment. The State will not modify the scope of costs, time study methodology or the annual cost reporting methodology without CMS approval.

6. Audit:
All supporting accounting records, statistical data and all other records related to the provision of the targeted case management services delivered by DHS is subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted by DHS, the Oregon Health Authority's Medicaid payment rate for the said period is subject to adjustment.

Documentation and Reporting of Cost

DHS recognize the TCM services provided via this amendment on a monthly basis. In addition, these costs are claimed quarterly on the CMS-64.