DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

MAR 0 9 2012

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301

RE: Oregon State Plan Amendment (SPA) Transmittal Number 11-007

Dear Dr. Goldberg:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oregon State Plan Amendment (SPA) Transmittal Number 11-007. This SPA was submitted to reflect specified provider rate reductions as required based upon Oregon's 2011-13 legislatively approved budget.

This SPA is approved effective August 1, 2011, as requested by the State.

If you have any questions concerning this SPA or require further assistance, please contact me, or Bill Vehrs of my staff at (503) 399-5682 or bill.vehrs@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

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: **11-07**

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
8/1/11 (P&I)

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 D

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ (913,474) (P&I)
b. FFY 2012 $ (5,486,077) (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 1,1a, 1a.1
Attachment 3.1-A, pages 2-a, 2-b, 2-c, 3-b, 3-b.1 (P&I)
~~Attachment 3.1-A, pgs 4-b and 4-c (P&I)~~ (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 1,1a.1,**1a (P&I)**
~~Attach 3.1-A, pages 2-a, 2-b, 2-c, 3-b, 4-b, 4-c (P&I)~~ (P+I)

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to reflect specified provider rate reductions as required based upon 11-13 legislatively approved budget.

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

14. TITLE: Director, Division of Medical Assistance Programs

15. DATE SUBMITTED: July 14, 2011

16. RETURN TO:
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 14, 2011

18. DATE APPROVED: MAR 0 9 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 0 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL [redacted]

21. TYPED NAME: Carol J.C. Peverly

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

23. REMARKS:

7/5/11 - Pen & Ink changes authorized by the State.

9.27.11 - state authorized changes to box 8 and box 9 for additional pages (adding 3.1-A pgs)
9.28.11 - state authorized changes to Box 8 (adding 4-b,4-c)
10/11/11 - State authorized Pen & Ink changes to Box 7.
1/9/12 - Pen and ink changes authorized by the State.

FORM HCFA-179 (07-92)

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

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

LIMITATIONS ON SERVICES (Cont)

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 in accordance with the American Academy of Pediatric Dentistry's Dental Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents.

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 Medical Assistance Programs medical or dental consultants.

4.c. Family Planning Services

Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size. Clients may seek family planning services from any provider enrolled with the Division, even if the client is enrolled in a Managed Care entity. Family Planning services include: Annual exams; Contraceptive education and counseling to address reproductive health issues; Laboratory tests; Radiology services; Medical and surgical procedures, including tubal ligations and vasectomies; Pharmaceutical supplies and devices.

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

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

LIMITATIONS ON SERVICES

5. a. and b. Physicians Services, Medical and Surgical Services provided by dentist

Payment for physicians and oral surgeon 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 payers and after concurrence by appropriate provider representation. The DMAP 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), Current Dental Terminology (CDT) and HCPCS codes are the basis of medical terminology and procedure descriptions.

Reimbursement for non-emergency services provided by out-of-state physicians or oral surgeons, 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 is on the same basis as services provided in Oregon.

The Division may disallow payment for physicians' or oral surgeon services provided during inpatient hospitalizations in which prior approval was required but not obtained.

6. a. Podiatrist Services

Selected procedures require prior authorization of payment. Routine foot care is excluded from coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS ON SERVICES (Cont.)

6.b. Optometrist Services

Coverage includes all vision services for children and pregnant women (including routine vision exams, fittings, repairs, therapies and materials) provided by ophthalmologists, optometrists and opticians.

DMAP will not provide routine vision services and material to non-pregnant adults age 21 and older, except for clients with specific medical diagnoses.

Services that require prior authorization include contact lens, except for the medical condition of Keratoconus, vision therapy for adults or unclassified CPT procedures.

6.c. Chiropractor Services

Chiropractic services are in accordance with 42 CFR 440.60. Coverage is limited to rheumatoid arthritis and other inflammatory polarthropathies, neurological dysfunction in posture and movement caused by chronic conditions, disorders of the spine with neurologic impairment, peripheral nerve entrapment, osteoarthritis and allied disorders, brachial plexus lesions and migraine headaches.

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

LIMITATIONS ON SERVICES (Cont.)

6. d. Other Practitioner Services

The following practitioners are covered for services within their scope of practice as defined in Oregon Revised Statutes and the applicable Boards governing them:
Naturopaths; Licensed Direct Entry Midwives; Acupuncturists; Denturists; Dental hygienists with an Expanded Practice Permit(EPP), Certified Nurse Anesthetist and Certified Nurse Practitioners with the following specialty designations: Acute Care Nurse Practitioner (ACNP); Adult Nurse Practitioner (ANP); Neonatal Nurse Practitioner (NNP); Psychiatric/Mental Health Nurse Practitioner (PMHNP) and Women's Health Care Nurse Practitioner (WHCNP); Geriatric Nurse Practitioner (GNP).

7. a. Home Health Care Services

Coverage and provider qualifications are in accordance with 42 CFR 440.70. Intermittent or part-time nursing services are provided to eligible clients in their homes according to a written plan of treatment. Home health services must be prescribed by a physician and the signed order must be on file at the Home Health Agency. The plan of care must be reviewed and signed by the physician every 60 days to continue services. Prior authorization is required for home health services. Home Health services are provided by a registered nurse when no home health agency is available. Services are provided by home health agencies that meet conditions for participation in Medicare. Services are not covered if not medically appropriate, Medical Social Worker services, Registered Dietician counseling. Services requiring prior authorization are: Skilled nursing services and all therapy services. Some services are limited; skilled nursing visits are limited to two visits per day; therapy services are limited to one visit or evaluation per day.

7. b. Services of Home Health Aide

Services of a home health aide, employed by a Home Health Agency, giving personal care are provided according to a plan of treatment. All requirements listed for Home Health Services above apply to Home Health Aide services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS ON SERVICES (Cont.)

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

Medical supplies, equipment and appliances suitable for use in the home are provided when medically necessary and ordered by a treating physician. The medical equiptment or appliance must be approved for marketing and registered or listed as a medical device by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended.

DMEPOS items are not covered include, but is not limited to; when the item is not primarily medical in nature; for personal comfort or convenience of client or caregiver; a self-help device; not therapeutic or diagnostic in nature; inappropriate for client use in the home (e.g., institutional equipment like an oscillating bed); for a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

General:
The division pays the lesser of the usual and customary charge or a fee based on the methods outlined for the program according to Attachment 4.19-B. The provider's usual and customary fee is the fee charged by the provider to the general public for the particular service rendered.

Where applicable, the maximum allowable fees are established using the CMS Resource Based Relative Value (RBRVS) Scale methodology as published in the Federal Register annually, times an Oregon specific conversion factor. Except as otherwise noted in the plan, the agency's rates were set as of 8/1/11 and are effective for dates of services on or after that date. The reimbursement methods listed in this section of the plan are available on the agency's website http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml

State developed fee schedule rates are the same for both governmental and private providers.

Provider type/ Service type	Payment method
3. Laboratory and Radiology services	Clinical Laboratory and Pathology Procedures are paid at 70% of current Medicare fee updated annually as published by Medicare. Other lab and X-ray services are paid on a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.
5.a. Physician services, Physician Assistant 5.b. Medical and surgical services furnished by a dentist 6. a. Podiatrists' services 6. c. Chiropractors' services	Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor. Fees for drugs administered in the provider's office is based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25%. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Anesthetists payment for services is a state-wide fee schedule which utilizes the current American Society of Anesthesiology Relative Value base units plus time.
6. b. Optometrist services Ophthalmologist, optometrists.	Exam and dispensing: Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.
6. d. Other Practitioner Services; Naturopath, Acupuncturist, Certified Nurse Practitioner and Licensed Direct Entry Midwives	Payment for services is a state-wide fee schedule which utilizes the RBRVS Scale, times the Oregon specific conversion factor.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Provider type/ Service type	Payment method
6.d. Nurse Anesthetists	Payment for services is a state-wide fee schedule which utilizes the current American Society of Anesthesiology Relative Value base units plus time.
7. Home Health	Payment for services is a state-wide fee schedule based upon 74% of the most recently accepted Medicare Cost reports.
7. c. Medical Supplies and Equipment.	Payment for services is a state-wide fee schedule. Ostomy supplies are 95.4% of 2010 Medicare fee schedule, Complex Rehab items are 90.5% of 2010 Medicare fee schedule, all other items are 80% of 2010 Medicare fee schedule. Unlisted procedures are based upon acquisition cost plus 20%.
8. Private Duty Nursing Services:	Payment for services is a state-wide fee schedule based on community wages set in 1993 with periodic CPI increases.
10. Dental services Dentist, Dental hygienist with an Expanded Practice Permit	Payment for services is based on a state-wide fee schedule. The fees were developed from a survey of other State Medicaid Programs and the largest commercial dental insurance carrier in Oregon.
11. Physical Therapy, Occupational Therapy, Speech, Hearing, Audiology services.	Payment for services is a state-wide fee schedule which Utilizes the RBRVS Scale, times the Oregon specific conversion factor.
12.b. Dentures, Denturist	Payment for services is based on a state-wide fee schedule. The fees were developed from a survey of other State Medicaid Programs and the largest commercial dental insurance carrier in Oregon.
12.c. Prosthetic Devices	Payment for services is a state-wide fee schedule based on 83% of 2010 Medicare fee schedule. Unlisted procedures are based upon acquisition cost plus 20%.
12. d. Eyeglasses, contacts and hardware	Payment for services is a state-wide fee schedule utilizing a contract with a federally qualified rehabilitation facility. The contract is effective for service on or after 10/1/11.
24.a. Transportation	Payment for emergency medical transportation services is a state-wide fee schedule.
24.f. Personal Care Services	For Clients Served through Seniors and People with Disabilities: Payments are made to individual providers based on state-wide uniform hourly rate. The fee schedule is the same for both governmental and private providers. The rate for Personal Care Services for Clients Served through Seniors and People with Disabilities was last updated on 1/1/11 and is applicable to services rendered on or after that date. The rate is posted on the agency web at: http://www.oregon.gov/DHS/spd/provtools/rateschedule.pdf.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Provider type/ Service type	Payment method
24.f. Personal Care Services	For Clients Served through the Addictions and Mental Health Divisions (AMH): For services provided in licensed community-based residential settings, Payments are made to individual providers (in accordance with Chapter 309 of the Oregon Administrative Rules for personal care services) based on the special needs of an individual, identified through an assessment performed by an approved practitioner recognized by AMH as a Qualified Mental Health Professional and incorporated into an individual plan of care. The rate for Personal Care Services for Clients Served through Addictions and Mental Health Division was last updated on 1/1/11 and is applicable to services rendered on or after that date. The rate is posted on the agency web at: http://www.oregon.gov/DHS/mentalhealth/tools-providers.shtml For Children in a Foster Care Setting: Payments are made to individual providers (in accordance with a fee schedule for personal care services maintained in Chapter 413 of the Oregon Administrative Rules) based on the special needs of an individual child, identified through an assessment performed by an Registered Nurse and incorporated into an individual plan of care. Payment is only made for the days the child is eligible for and receives personal care services. The fees were last updated September 1, 2009. There are four levels of care: Level 1 - $47.77 per week; Level 2 - $95.30 per week; Level 3 - $143.07 per week; and Level 4 - In extraordinary situations where continuous observation and/or interventions may be required, individualized rates are developed based on the child's needs.