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

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy(Continued)
42 CFR 435.217	X	4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
	X	5.	PACE Enrollees.

*Agency that determined eligibility for coverage

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

Name and address of State Administering Agency, if different from the State Medicaid Agency.
Oregon Department of Human Services, 500 Summer St. NE, Salem, OR 97301

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: Groups as provided under 42 CFR 435.236 Individuals in institutions who are eligible under a special income group with income under 300% of SSI).

(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.)

Spousal impoverishment eligibility rules apply.

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 0185.R05.01.

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

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) X SSI
   - (b) _____ Medically Needy
   - (c) _____ The special income level for the institutionalized
   - (d) _____ Percent of the Federal Poverty Level: _____%
   - (e) __ Other (specify): _____

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.

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

6._____ The amount is determined using the following formula:
The amount allowed in Sec. 1924 of the Act _____
7._X___ 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. __N/A_ 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.

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

(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.

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

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. X 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:

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

II. Rates and Payments

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

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

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.

PACE Rate Methodology and Upper Payment Limit Calculation

The following information is organized and is consistent with the format of the resource document which reflects the PACE: Upper Payment Limit and Capitation Rates development for the current PACE Contract. The Upper Payment Limit and PACE Capitation rates are developed and submitted by Oregon DHS Actuarial Service Unit. The Upper Payment Limits calculated for the PACE program are 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 PACE service area who are age 55 or older, meet the state's criteria for long-term care eligibility with a service priority level of 1-13, and are Medicaid eligible (which excludes SLMB and QMB-only who are not Medicaid eligible and Medically Needy individuals)

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.

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

PACE Rate Methodology and Upper Payment Limit Calculation(cont)

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.

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 into LTC service priority level groupings.

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

PACE Rate Methodology and Upper Payment Limit Calculation (cont)

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 PACE service area.is created. PACE participants were excluded from this population.
2. This eligibility information was matched against the LTC claims data to create the claims experience for the PACE-eligible population.
3. Claim data was summarized to obtain information on total amounts for the data period by service category and LTC service priority level groupings.
4. The PACE eligibility information is used to develop member months of eligibility. These figures were then used as the denominator in the calculation of per capita costs.
5. Trend rates were developed for various service categories.
6. 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. 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.